

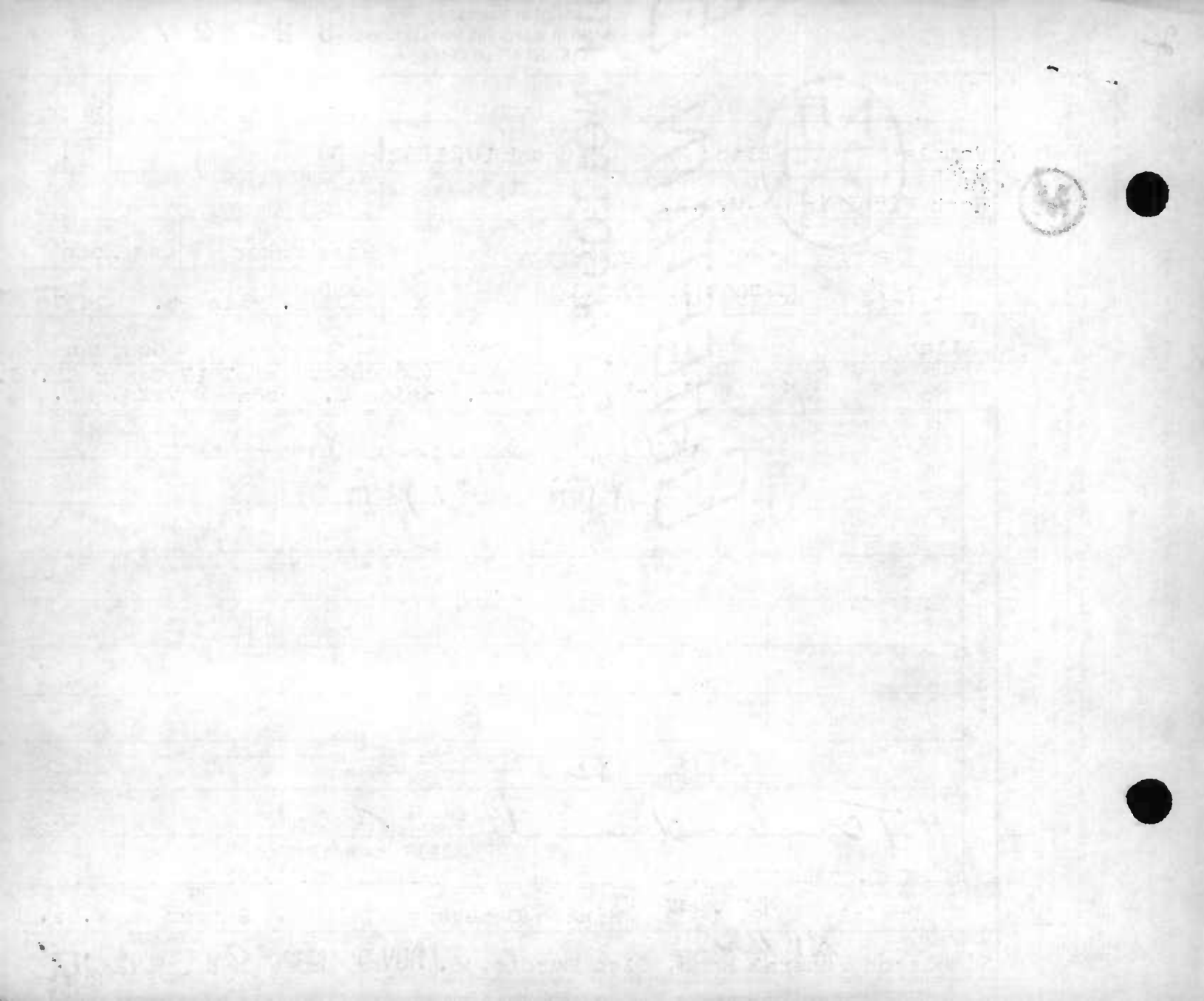
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certificates, pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 7 7 3 4 EST	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
HAZEL BEATRICE ALLEN								NOVEMBER 5, 1982		10:50PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Female		Black		August 10, 1892		90					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		U.S.A.				ANNE ARUNDEL COUNTY MD.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Home maker		Own Home					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. COUNTY		19. CITY OR TOWN		20. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. STREET ADDRESS	
West Virginia		Brier		Ronceverte		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		509 E. Main St.		24970	
22. FATHER'S NAME FIRST MIDDLE LAST		23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		25. SOCIAL SECURITY NO.		26. INFORMANT (Daughter) ADDRESS		27. 7917 Tower Ct. Rd. Md.	
Allen		Pack		Mary Anne Goodwin		No		N/A		129-18-5257	
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age - 8 pain Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>STADH. CRPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		30. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
31. DATE OF OPERATION		32. CONDITION FOR WHICH OPERATION WAS PERFORMED		33. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		34. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
35. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		36. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
38. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		39. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		40. LOCATION STREET CITY OR TOWN COUNTY STATE							
41. I certify that (I) (this hospital) attended the deceased from 1982 to 1982, that (I) (we) lost saw the deceased alive on 11/5/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		42. SIGNATURE		43. DEGREE		44. DATE SIGNED					
45. PHYSICIAN'S NAME (TYPE OR PRINT)		46. ADDRESS		47. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
HAMID A. TOWHIDIAN, M.D.		3236 MOUNTAIN ROAD PASADENA, MD. 21122									
48. BURIAL, CREMATION, REMOVAL (SPECIFY)		49. DATE		50. NAME OF CEMETERY OR CREMATORY		51. LOCATION CITY OR TOWN COUNTY STATE					
Burial		November 9, 1982		Hinton Cemetery		Hinton Summer W.Va.					
52. FUNERAL DIRECTOR NAME		53. DATE REC'D. BY REGISTRAR		54. REGISTRAR'S SIGNATURE							
Singleton Funeral Home, Glen Burnie, Md.		NOV 9 1982		John J. Gough							

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH ANY FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD S. ANDERSON</b>			2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			2b. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		
3. SEX <b>male</b>			4. RACE <b>white</b>			5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			6. AGE (IN YEARS) LAST BIRTHDAY <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel co.</b>		
10. CITY OR TOWN OF DEATH <b>Gen Burnie</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North-ARUNDEL Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laboratory Tech.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Riviera Bch.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE <b>R.</b> LAST <b>Anderson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Slade</b> LAST <b>Slade</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>213-20-4506</b>		
17. INFORMANT <b>Esther Lou Anderson (same as 13e)</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound. Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input type="checkbox"/> A.M. MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Self-inflicted gunshot wound</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET <input type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/>			21g. LOCATION STREET <input type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. ACTUAL SIGNATURE <b>E. Linhardt</b>			22c. TITLE (SPECIFY) <b>Deputy</b>			22d. MEDICAL EXAMINER <b>MD.</b>		
22e. EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>			22f. ADDRESS <b>Annapolis - MD.</b>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/17/82</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Pres. Cem.</b>			23d. LOCATION CITY OR TOWN <b>Madonna</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			24. FUNERAL DIRECTOR NAME <b>Balto., Md. 21225</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			26. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>			27. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			28. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		



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 3. *[Faint, illegible text]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 1 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph E Anderson			2a. DATE OF DEATH MONTH DAY YEAR 11 20 82			2b. HOUR 9:30 AM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 27 42		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOK BINDER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN DEALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES R. ANDERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE G. McVEARRY			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 578-56-9257	
17. INFORMANT ANN R. ANDERSON			18. ADDRESS 935 MAIN ST. DEALE, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Hepato-Renal Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis with Esophageal Varices - 1 yr DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia 2° to Coag Postive PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Staph and Klebsiella									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
19a. DATE OF OPERATION 11-9-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Esophageal Varices				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the undersigned) attended the deceased from Oct 28, 19 82, to Nov 20, 19 82, that (I) (we) last saw the deceased alive on 19 Nov, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Gary M. Richardson, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-20-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary M. Richardson, M.D.					22e. ADDRESS 104 Forbes Street, Annapolis, Md 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11/22/82		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD				
24. FUNERAL DIRECTOR NAME ADDRESS HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN. MD.					25a. DATE REC'D. BY REGISTRAR NOV 22 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 3 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at 475-5333 or 475-5334.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 7 3 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph H Anderson SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-10-82</b>		2b. HOUR <b>9:30 AM</b>
3. SEX <b>M</b>	4. RACE <b>2 B.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-12-12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A.G.H.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co.</b> MD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>A.A.</b> 13d. CITY OR TOWN <b>ANNAPOLIS</b>			13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>199 Clay Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY WOODWARD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MARY ANDERSON 199 Clay Street Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>4408</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6h - years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>anemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1981</b> to <b>11-10-1982</b> , that (I) <del>was</del> last saw the deceased alive on <b>11-10-82</b> and that in <del>my</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did not) view the body after death.					
22b. SIGNATURE <b>F. M. Shipley</b> DEGREE				22c. DATE SIGNED <b>01.12.82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. M. SHIPLEY MD</b>				22e. ADDRESS <b>Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-15-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILL CREST CEMETERY</b>	
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		24b. ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 3 8

1. FOR STATE REGISTRAR		REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
HELEN G ARMSTRONG				NOVEMBER 04, 1982	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		April 8, 1920	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		U.S.A.		62 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		ANNE ARUNDEL COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Packer		Allied Chem. Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Anne Arundel		Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Louis Smallwood		Agnes Slaughter		13e. STREET ADDRESS	
				7926 Main St. 21226	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		218-14-0145		Balto., Md. 21226	
				Mr. Gordon D. Armstrong 308 Greenland Beh. Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
JOSE PRESBITERO, M.D.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
JOSE PRESBITERO, M.D.				7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND, 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11/8/1982		Glen Haven Mem. Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mc Cully Funeral Home of Pasadena		NOV 9 1982		John J. Connel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP \_\_\_\_\_

DHMH - 16 50M 4/B2  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 3 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles William Ballard</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-2-82</i>			2b. HOUR <i>4:5A</i> M	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7 17 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Arkansas</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Edgewater</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pleasant Living Conv. Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Govt. Purchasing</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>DC</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>Wash.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander Burton Ballard</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Tdg Lee</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-40-4437</i>		17. INFORMANT <i>DAUGHTER</i>		ADDRESS <i>3921 W ST. NW WASH. D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4292</i> IMMEDIATE CAUSE (a) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Jon B Lowe MD</i> DEGREE						22c. DATE SIGNED <i>11-2-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jon B Lowe MD</i>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>Nov. 5 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Mont. Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>John F. DeVoe</i> ADDRESS <i>Home WASH. D.C.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>NOV 8 1982 John F. DeVoe</i>			

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 7 7 4 0  
REG. NO. EST

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		JOHN M. BARTON		NOVEMBER 12, 1982		1:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		April 17, 1927		55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Carpenter		Home Improve.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
Hal Barton		Frances Jones		1402 Colony Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		230-28-7009		June M. Fox		1402 Colony Road	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

1629 DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) SMALL CELL CARCINOMA LUNG

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas D. Brown</u> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS BROWN, M.D.				22e. ADDRESS BALTIMORE, MARYLAND 21205 JOHNS HOPKINS HOSPITAL, ONCOLOGY CENTER			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		11/16/82		Westview Mem. Pk.		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hwy. Baltimore, Md. 21225		25a. DATE REC'D. BY REGISTRAR NOV 16 1982	
						25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5420.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 7 4 1	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MADELINE B. BEERY</b>				2a. DATE OF DEATH MONTH <b>NOV</b> DAY <b>30</b> YEAR <b>1982</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>8</b> YEAR <b>1912</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2570 RIVA RD.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL CNTY MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		13a. STREET ADDRESS <b>2570 RIVA RD.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>	
14. FATHER'S NAME FIRST <b>—</b> MIDDLE <b>—</b> LAST <b>PFEIFER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>—</b> MIDDLE <b>—</b> LAST <b>UNKNOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>190-09-5014</b>		17. INFORMANT <b>THOMAS E. BEERY</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LUNG</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>NONE</b> 19 <b>82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <del>the</del> hospital attended the deceased from <b>NOV 29</b> , 19 <b>82</b> , to <b>NOV 30</b> , 19 <b>82</b> , that (1) <del>was</del> lost saw the deceased alive on <b>NOV 29</b> , 19 <b>82</b> , and that (1) <del>was</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) <del>not</del> view the body after death.					
22. SIGNATURE <b>James M Blake Jr MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>NOV 30, 1982</b>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES M BLAKE JR MD</b>		22b. ADDRESS <b>2510 RIVA ROAD #222 ANNAPOLIS MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 3, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW CEMETERY</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>		ADDRESS <b>501 RITCHIE HWY. SEVERNA PARK, MD. 21144</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SYKESVILLE CARROLL MD</b>	
25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 1 4 2			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN FRANCES BEHLKE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 4 82</b>		2b. HOUR <b>A</b> M	
1. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 5 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HAVE HUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>A.A. GEN. HOSPT</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. 13b. COUNTY <b>MD. 13b. COUNTY</b>				13c. CITY OR TOWN <b>EDGEWATER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES H. CHRISTENSON</b>				15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>HADIE E. DAVIS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 051441</b>		17. INFORMANT ADDRESS <b>Ralph G. BEHLKE #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4254 DUE TO, OR AS A CONSEQUENCE OF b) <b>Diabetic cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>Diabetic mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acid renal failure</b>							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/19/79</b> , 19 <b>82</b> , to <b>11-4</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>10-7</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>SAMUEL MD</b>				DEGREE		22c. DATE SIGNED <b>11-4-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Mitchell MD</b>				22e. ADDRESS <b>205 Ridge/Ave 1000</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>11/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANDREWS FATHERS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PLAYO AA MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>TAYLOR FUNERAL CHAPEL Annapolis, MD.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 10 1982 John J. Smith</b>			

MEDICAL CERTIFICATION



LILLIAN FRANCES BENTLEY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			KNOWN OF ESTIMATED			MONTH DAY YEAR			2b. HOUR				
MARY LOUISE BELITZ						11-21-82						11-21-82			11:30				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		24 HOUR			
F W		W		9/18/49		33 YRS		MONTHS DAYS		HOURS MIN		11-21-82		19		11:30			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Anne Arundel County				MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Pasadena				239 Bay Front Drive				Executive				Oil				21401			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				A.A.				Annapolis				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				501 Dreams Landing Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
Albert				Beehler				Mary Louise Dyer				No				Mr. Albert Beehler, Balto., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Gunshot wound of head																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				11-21-82				self/inflicted											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
				house				239 Bay Front Drive Pasadena, Maryland											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				MARGARITA A. KORELL, M.D.				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE 11-22-82 SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				11/23/82				Lorraine Park				Balto., MD							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Henry W. Jenkins & Sons Co.				NOV 23 1982				John J. Casper											
4905 York Road Balto., MD 21212																			

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11 103000 11 103000  
HARRY W. JENNINGS & SONS CO.  
4000 York Road, Baltimore, MD 21212

Baltimore

MD

No

Mr. Albert Beahler, Baltimore, MD

Albert Beahler

Mary

Louis

John

Maryland, A.A. 1901 Year - Jan 1, 1901

Executive

City

Maryland

USA

2 18 1901

P. W.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use at the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 4 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>KELMA VIRGINIA BLANKENSHIP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22 '82</b>			2b. HOUR <b>8:40 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 26 '04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT SUCH A FACILITY, GIVE STREET ADDRESS) <b>A.A. GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOKKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>APT. COMPLEX</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. STREET ADDRESS <b>660 AMERICANA DR APT 53</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>STEPHEN E. FERRIER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLIVE O. JONES</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>312-07-4178</b>	
17. INFORMANT <b>PENNY MCNAMARA</b>		17. ADDRESS <b>827 BURN VISTA AV.</b>		17. CITY OR TOWN <b>ANNAPOLIS</b>		17. STATE <b>MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Post-op bilateral BKA amputation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>about 68 hrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION <b>10/10/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pericardial Nodular Disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>11/22</b> 19 <b>82</b> , to <b>11/22</b> 19 <b>82</b> , that (I) <b>(last)</b> saw the deceased alive on <b>11/22</b> 19 <b>82</b> , and that in (my) <b>(last)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(was told)</b> (did not) view the body after death.		22b. SIGNATURE <b>Richard I. Hochman</b>		22c. ADDRESS <b>16 Murray Ave., Annapolis, MD</b>		22d. DATE SIGNED <b>11/23/82</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/27/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT</b>		23d. LOCATION CITY OR TOWN COUNTY <b>METTES IND.</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>		24. ADDRESS <b>ANNAPOLIS MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 24 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

MEDICAL CERTIFICATION

RECEIVED  
JUN 10 1964

Richard L. Lockman

10 Murray Ave., Annapolis, MD 21403

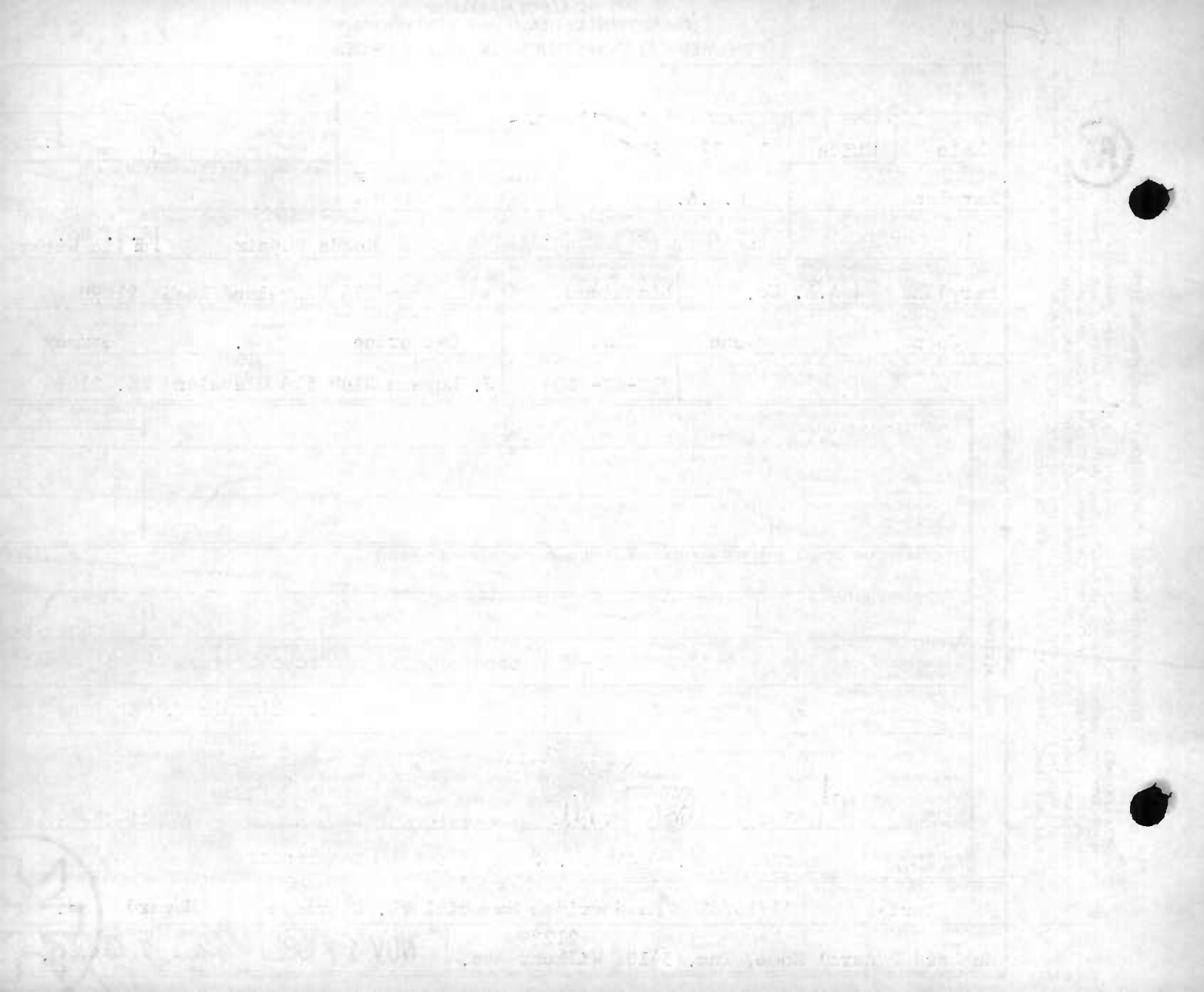
Boxing  
11/1/62 Mr. Bennett  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 7 7 4 5	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARK K. BLOB										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 11-15-82	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 11 62	6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 11-15-82	2d. HOUR 2:30A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roads Repair		12b. KIND OF BUSINESS OR INDUSTRY Public Works				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN A.A. Co.	13c. CITY OR TOWN Linthicum	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 516 Cleveland Road 21090			
14. FATHER'S NAME FIRST MIDDLE LAST John Eugene Blob				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine P. Kearney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-88-7206		17. INFORMANT ADDRESS J. Eugene Blob 516 Cleveland Rd. 21090					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8153 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 1:26AM 11-15-82 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger of motorcycle/fixed object impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION Hammonds Ferry Rd. Linthicum, Maryland STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 11-15-82			
EXAMINER'S NAME (TYPE OR PRINT) margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/15/82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR NOV 17 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY E DITH BOWEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 2 1982</b>			2b. HOUR <b>11:11 A M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9 7 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Chesapeake Beach Md. USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL CO MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>household</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Deale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6th &amp; Main St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Stallings</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Fowler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-34-9670</b>		17. INFORMANT ADDRESS <b>Charles T. Bowen Sr. same as 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart all Ca lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/81</b> , 19____, to <b>11/2/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/2/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>B S P WATKINS</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/3/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B S P WATKINS</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Sam J. Canish</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 27747			
1. DECEASED NAME (TYPE OR PRINT) <b>Mallroy B. Brock</b>				2a. DATE OF DEATH MONTH DAY YEAR 11-22-82 2:25 M			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR 4-24-28		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FLORIDA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>	
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>ARNOLD</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>134 CLUB RD. 21012</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CARY — BROCK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY — GAY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>262-36-5581</b>		17. INFORMANT <b>MAURIO BROCK</b>		ADDRESS <b>133 NORFOLK RD. SEVERNA PARK MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5714</b> IMMEDIATE CAUSE (a) <b>Hepatic cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic hepatitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from <b>August</b> 19 <b>82</b> , to <b>11/22</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael N. Peters M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/22/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael N. Peters</b>		22e. ADDRESS <b>2510 Riva Rd. Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Nov. 24, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PIRESVILLE BALTIMORE MD</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCE</b>		ADDRESS <b>501 RITCHIE HWY. SEVERNA PARK, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gough</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leroy Allen <i>Buhrman</i>			2a. DATE OF DEATH MONTH DAY YEAR Nov. 15, 1982		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 25, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner	12b. KIND OF BUSINESS OR INDUSTRY car wash		
13a. STATE Md.		13b. COUNTY AS.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 10 Granada Rd.
14. FATHER'S NAME FIRST MIDDLE LAST Louis Allen <i>Buhrman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Engelman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT ADDRESS Wayne Buhrman Granada Rd. Pasadena Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>ASCVD</i> <i>5850</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic CHF</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Chronic renal failure</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>old cvs, arthritic, gout</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-1-82</i> , 19 <i>82</i> , to <i>11-15-82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11-1-82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mustafa C. Oz</i> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-15-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mustafa C. Oz MD		22e. ADDRESS 605 B & A Blvd Secina park			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/19/82	23c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS 12 Ridgely Ave. Ann. Md.	25a. DATE REC'D. BY REGISTRAR NOV. 18 1982	25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

BP

CONFIDENTIAL



CONFIDENTIAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 4 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Curtis A. Chase</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>21</b> YEAR <b>82</b>			2b. HOUR <b>1:30 PM</b>	
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>04</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>GALESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE LAST <b>CHASE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE LAST <b>CHASE</b>		16. ADDRESS <b>Galesville, Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>		17. INFORMANT <b>RAYMOND WINDBOR</b> ADDRESS <b>4851 Church La.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATO-RENAL SYNDROME</b> <b>5715</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATIC CIRRHOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b> <b>5 YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SPONTANEOUS PERITONITIS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (the) hospital attended the deceased from <b>11-9</b> , 19 <b>82</b> , to <b>11-21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edward S. Beatty</b>				22c. DATE SIGNED <b>11-22-82</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11-24-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Growsville A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25. DATE REC'D BY REGISTRAR <b>NOV 26 1982</b>		26. REGISTRAR'S SIGNATURE <b>John J. Gwinn</b>	

MEDICAL CERTIFICATION





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 2 7 7 5 0

 FOR  
 1. STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Francis Chesgreen			2a. DATE OF DEATH MONTH DAY YEAR 11 10 82		2b. HOUR 6:10a M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 7 18 24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Gambrills	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 558 St. Mary's Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retiree	12b. KIND OF BUSINESS OR INDUSTRY US Govt	
13a. STATE MD			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Gambrills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James William Chesgreen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erzulla Clare Peery		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218 12 3724		17. INFORMANT ADDRESS Ellen Chesgreen same as above	

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

 IMMEDIATE CAUSE (a) Hepatitis with post-necrotic cirrhosis &  
 5715 liver failure

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

8 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/79, 19, to 11/10, 19, 82, that (I) (we) last saw the deceased alive on 11/09/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Lawrence R. Gallager, M.D.	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence R. Gallager, M.D.	22e. ADDRESS St. Agnes Medical Center 3455 Wilkens Ave. Balto., MD 21229		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 15, 1982	23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Savage, Maryland
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md		25a. DATE REC'D. BY REGISTRAR NOV 23 1982	25b. REGISTRAR'S SIGNATURE J. C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Lillian Clark			2a. DATE OF DEATH MONTH DAY YEAR November 1, 1982			2b. HOUR 3 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Severn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1024 Reece Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1024 Reece Road 21144								
14. FATHER'S NAME FIRST MIDDLE LAST John W. Shipley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iantha Cromwell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 1032 Reece Rd., Severn, Md. Mr. Norman W. Clark, Jr. (son) 21144				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis General</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 14</u> , 19 <u>82</u> , to <u>Nov 1</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Oct 19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Joseph Taler, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1 NOV 82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH TALER				22e. ADDRESS 95 AQUAHART Rd., Glen Burnie, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3 NOV '82		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery Harmons		23d. LOCATION CITY OR TOWN COUNTY STATE A.A. Co. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS J. Easter SINGLETON FUNERAL HOME, GLEN BURNIE, MD.				25a. DATE REC'D. BY REGISTRAR NOV 3 1982				
				25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>				

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annette Francis Cogswell			2a. DATE OF DEATH MONTH DAY YEAR November 5 1982			2b. HOUR 0956am M	
3 SEX Female		4 RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR Sept 26 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10 CITY OR TOWN OF DEATH Ft. Meade, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Comm. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cleaning		12b. KIND OF BUSINESS OR INDUSTRY APTS	
13a STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Clara		13e STREET ADDRESS Clark Rd. C-35 (Mark Drive)		13f. STREET ADDRESS Clark Rd. C-35 (Mark Drive)	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 220-07-7292		17. INFORMANT Son/Clyde Edward Cogswell, Jr.		17b. INFORMANT Clark Rd. C-35 (Mark Drive)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dead On Arrival</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (a) (this hospital) attended the deceased from <u>5 Nov</u> 19 <u>82</u> , to <u>5 Nov</u> 19 <u>82</u> , that <u>X</u> (we) last saw the deceased alive on <u>N/A</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) <u>N/A</u> view the body after death.							
22a SIGNATURE <i>Clarion E. Johnson</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5 Nov 82			
22b PHYSICIAN'S NAME (TYPE OR PRINT) Clarion E. Johnson, CPT, MC M. D.		22e. ADDRESS Kimbrough Army Comm. Hospital, Ft. Meade, Md.					
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 11/8/82		23c NAME OF CEMETERY OR CREMATORY Glen Haven		23d LOCATION Glen Burnie, Md.	
24 FUNERAL DIRECTOR Barranco Funeral Home, Glen Burnie, Md.		25a DATE REC'D. BY DEPARTMENTAL REGISTRAR NOV 8 1982					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



George Washington University  
Library  
1000 19th Street, N.W.  
Washington, D.C. 20037

Author: [illegible]  
Title: [illegible]  
Date: [illegible]  
Call Number: [illegible]

Subject: [illegible]  
Notes: [illegible]

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Accession Number: [illegible]

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**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 7 1 5 3

1. DECEASED NAME (TYPE OR PRINT) <b>Russell B. Coover</b>		2a. DATE OF DEATH MONTH <b>Nov.</b> DAY <b>25</b> YEAR <b>82</b>		2b. HOUR <b>9</b> MIN <b>15</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>24</b> YEAR <b>01</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>YORK Co. PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSTRUCTOR</b>		11. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC EDUCATION</b>	
12. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GEN. HOSP.</b>		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>A.A.G.</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b>	
15. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16. STREET ADDRESS <b>76 RIVER DR</b>		17. ZIP CODE <b>21403</b>	
18. FATHER'S NAME FIRST <b>DANIEL J.</b> MIDDLE <b></b> LAST <b>COOVER</b>		19. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>EMMA</b> LAST <b>BILLET</b>		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR/DATE) <b>WW II</b>	
21. SOCIAL SECURITY NO. <b>577-24-3102</b>		22. INFORMANT <b>Edwin R. Coover</b>		23. ADDRESS <b>6816 Brookville Rd Chevy Chase MD 20815</b>	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain stem stroke</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that (I) (this hospital) attended the deceased from <b>1970</b> , 19____, to <b>Present</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/24/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		35. SIGNATURE <b>Peter F. VerKouwen MD</b>		36. DATE SIGNED <b>11-25-82</b>	
37. PHYSICIAN'S NAME (TYPE OR PRINT) <b>1419 Forest Dr. Annapolis, Md 21403</b>		38. ADDRESS <b>PETER F. VERKOUWEN</b>		39. DATE REC'D. BY REGISTRAR <b>NOV 30 1982</b>	
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		41. DATE <b>Nov 28, 1982</b>		42. NAME OF CEMETERY OR CREMATORY <b>mt Olivet</b>	
43. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>		44. ADDRESS <b>Annapolis MD</b>		45. REGISTRAR'S SIGNATURE <b>John J. Carlin</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN)
BURIAL	11/29/82	Ft. Lincoln	BREENTWOOD
24. FUNERAL DIRECTOR (NAME)	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Taylor Funeral Chapel	NOV 30 1982		John J. Conner

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/1979, 19, to 11/25, 1982, that (I) (we) lost saw the deceased alive on 11/24, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/27/82
22d. ADDRESS 1521 Ritchie Hwy		Arundel, Md.	

1. DECEASED NAME (TYPE OR PRINT) FLA R. Cappell COWAN			2a. DATE OF DEATH MONTH DAY YEAR 11-25-82		2b. HOUR 4 <sup>10</sup> PM
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7-01-02	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME	12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN CROWNSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS FAIRFIELD Loop RD 21032	
14. FATHER'S NAME Charles	MIDDLE Scott	15. MOTHER'S MAIDEN NAME Doris Bussey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-32-7806	17. INFORMANT ADDRESS 251 SHORE ACRES RD. ARNOLD, MD. 21012			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 5 4

REG. NO.

FOR  
STATE  
REGISTRAR

(M)

England USA  
white  
1 - 01 - 02  
The R. Cappel Co.  
221 State Street  
Boston, Mass.  
Charles  
244  
221 State Street  
Boston, Mass.

James C. ...  
1231 ...  
11/2/12  
11/2/12  
11/2/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Myrtle Crandall</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>11 28 82</i>			
3 SEX <i>Female</i>				2b. HOUR <i>10:30 A</i>			
4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MARCH 27 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEHOLD</i>	
13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>ANNE ARUNDEL</i>			
13c. CITY OR TOWN <i>CHURCHTON</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>ANDREW JACKSON PHIPPS</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY VIRGINIA EVANS</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>213-74-8945</i>			
17. INFORMANT ADDRESS <i>EVELYN C. WILLIAMSON LOCUST VALLEY, N.Y.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cormary occlusion</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V. disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic C.V. disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i> <i>years</i>
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No operation</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) <i>No injury</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i>			
22a. I certify that (1) this hospital attended the deceased from <i>11/10/82</i> to <i>11/28/82</i> , that (2) we lost <i>11/10/82</i> , and that in (my) <i>my</i> opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <i>CH Wirth</i>				EGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/28/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CH Wirth MD</i>				22e. ADDRESS <i>Lothian Md 20711</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>DEC. 1, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>QUAKER CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>GALESVILLE A.A. MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN., MD</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 30 1982</i>			
				25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>			

BP

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 9. The ninth part of the report  
 10. The tenth part of the report



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DMMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN CREEK</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <b>11 1 1982</b>				2b. HOUR <b>AM</b>	
3. SEX <b>F</b>	4. RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 23-00</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>11 1 1982</b>				2d. HOUR <b>AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel.</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Friendship</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rural</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Chase</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Maynard</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>213-74-8990</b>			17. INFORMANT ADDRESS <b>Helen Duppins Chesapeake Beach, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409 arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. L. Howard</b>			TITLE (SPECIFY) M.D. <b>Deputy</b>			MEDICAL EXAMINER			DATE SIGNED <b>11-1-82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>E. L. Howard</b>			ADDRESS <b>Annapolis, Md</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 5-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Chr. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lothian Anne Arundel Md</b>			
24. FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b>						ADDRESS <b>Box 31, Prince Frederick</b>		25a. FILED BY REGISTRAR <b>NOV 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 1 5 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mabel C. CROSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-82</b>		2b. HOUR <b>7:30</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 21 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANN ARUNDEL COUNTY, MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANN ARUNDEL</b>	13c. CITY OR TOWN <b>ARNOLD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES B. SKIDMORE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY LEE McATEE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>231-70-5986</b>		17. INFORMANT ADDRESS <b>721 MAGOTHY RD. WANEMA CURRENCE, DAUG., ARNOLD, MD. 21012</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MULTIPLE CVA's</b> (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Emphysema</b>			
19a. DATE OF OPERATION <b>11/14/82</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>82</b> , to <b>11/11</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/10/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>A. Plucis</b>	DEGREE	22c. DATE SIGNED <b>11/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Antonia Plucis</b>	22e. ADDRESS <b>1521 RITCHIE HIGH</b>		

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>11-15-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKINS, RANDOLF CO. W.VA.</b>
24. FUNERAL DIRECTOR NAME <b>IVES FUNERAL HOME</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

UNITED STATES OF AMERICA

WASHINGTON, D. C.

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

COTTON FIBER

WASH DC 100



UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

UNITED STATES OF AMERICA

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nannie B. Crowner			2a. DATE OF DEATH MONTH DAY YEAR 11 29 82			2b. HOUR 07 12 AM				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 25 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Gyrfar + Fish		
13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Colesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 452 W. Benning Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Walter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Harris			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 217-05-9978			17. INFORMANT Sylvia Butler			ADDRESS 1239 Crows Nest Ct. Annapolis, Md. 21403				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from December 19 79, to November 19 82, that (I) (we) lost saw the deceased alive on May 4 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Donald C. Rowe, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/29/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Rowe, M.D.			22e. ADDRESS 1616 Forest Dr. Annapolis 21403							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/2/82			23c. NAME OF CEMETERY OR CREMATORY Ebenzer			23d. LOCATION CITY OR TOWN COUNTY STATE Colesville A.A. Md.	
24. FUNERAL DIRECTOR NAME William Keese & Sons Mortuary, Inc. - Annapolis, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE John J. Canfield		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 5 9 REG. NO.		E.S.T.	
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
				ANNE MARIE CUNNINGHAM		NOVEMBER 1, 1982	
3. SEX				4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female				White		April 10, 1916	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
New Jersey				U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE				NORTH ARUNDEL HOSPITAL		Dietician	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				A.A.		Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Demeter = Kozma				Mary = Popp		13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				212-05-4555-D-7		Anne M. Perry same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>81</u> , to <u>11/1</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased give an above, (I) (we) (did) (did not) view the body after death.				22c. DATE SIGNED			
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/3/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
CHACKUMKAL V. CYRIAC, M.D.				7445-A FURNACE BRANCH ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial				11/4/1982		Glen Haven Cem.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Raymond C. Fink				Glen Burnie, Md.		NOV 3 1982 <u>[Signature]</u>	

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2c. HOUR	
Frank		A.		Delost				11		12		1982	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
MALE	WHITE	Aug 24, 1929		59 YRS.				11		12		1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		UNITED STATES				Anne Arundel County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel General Hospital		CARPENTER		U.S. NAVAL ACADEMY							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND		ANNE ARUNDEL		ANNAPOLIS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1158 St. GEORGE DR.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
FRANK		ANNA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		217-18-9539		DOUGLAS T. DELOST		(SAME AS 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Drowning		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
9540				DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY (est.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject jumped into water							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		Chesapeake Bay Bridge, Anne Arundel Co., Md.							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		11-12-82							
Dennis F. Smyth, M.D.		M.D. Assistant		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Dennis F. Smyth, M.D.		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
BURIAL		Nov. 15, 1982		CEDAR HILL CEMETERY		BROOKLYN		ANNE ARUNDEL		MD.			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT S. BARRANCO		501 RITCHIE HWY.		SEVERNA PARK, MD.		NOV 17 1982							

93817 NCT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 27761

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CARMON P. DeMARCO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-18-82</b>			2b. HOUR <b>3:10p.m.</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>81</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AAA Spad's Convalescent</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retailer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fruit &amp; Veg.</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Mayo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Liberato DeMarco</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Ursiolo</b>			16. STREET ADDRESS <b>365 Maple Ave. 21106</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>579-30-8266</b>		17. INFORMANT <b>Helen E. DeMarco</b>			ADDRESS <b>Same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Thrombosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4100</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Chronic HTN, Decuborous ulcers</b>										
19a. DATE OF OPERATION <b>11-5-82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic HTN, Decuborous ulcers</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11-5-82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>365 Maple Ave. Anne Arundel MD</b>					
22a. I certify that (1) (this hospital) attended the deceased from <b>11-5-82</b> to <b>11-18-82</b> , that (1) (we) lost saw the deceased alive on <b>11-5-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (do) not examine the body after death.										
22b. SIGNATURE <b>Errol A. Phillips</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Errol A. Phillips MD</b>			22e. ADDRESS <b>365 Maple Ave Anne MD 21106</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville AA MD</b>			
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons</b>			ADDRESS <b>Annapolis, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Lough</b>	



CARDON T. J. MARCO

11-18-22

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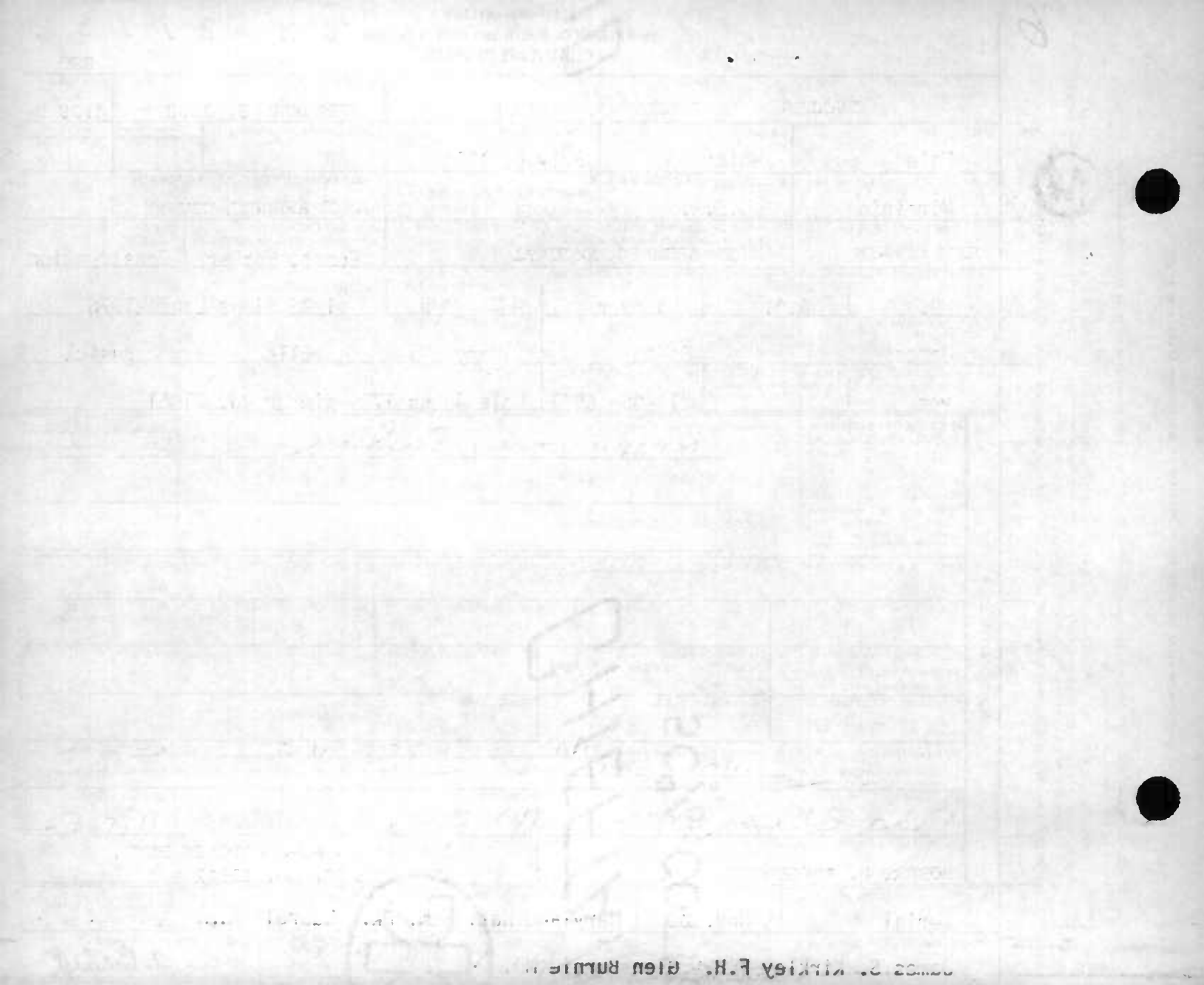
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5438.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 6 2
1. FOR STATE REGISTRAR		REG. NO.		EST
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES LONZY DEVAN</b>		20. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 5, 1982</b>		2b. HOUR <b>4:08 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 6, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Const. Worker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Hanover</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James DeVan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ella Kusick</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>219-05- 6991</b>		17. INFORMANT ADDRESS <b>Lola Johns 1709 Kimber Rd. 21061</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>7991</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>7/7</b> , 19 <b>25</b> , to <b>11/5</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Robert B. Kroopnick</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/5/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>		22e. ADDRESS <b>205 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MD. 21061</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8 Nov. 82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat. Mem. Pk.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel A.A. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley F.H. Glen Burnie MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Caserio</b>

BP



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BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 1 6 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Winifred P Dietrich</b>				2a. DATE OF DEATH MONTH <b>November</b> DAY <b>11</b> YEAR <b>1982</b> 2b. HOUR <b>1207p</b> M			
3. SEX <b>Female</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH MONTH <b>February</b> DAY <b>27</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. IF UNDER 1 YEAR MONTHS BAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Simpsonville, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Ft. Meade</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kimbrough Army Comm. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Highland</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>13355 Route 108</b>			
14. FATHER'S NAME FIRST <b>Winfield</b> MIDDLE <b>Parlette</b> LAST <b>Gambrill</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anne</b> MIDDLE <b>Gambrill</b> LAST <b>Gambrill</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>579-22-8759</b>		17. INFORMANT ADDRESS <b>John J. Dietrich smae as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>1 Day</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Acute renal failure on chronic renal failure - right lower lobe pneumonia</b>							
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9 NOV.</b> 19 <b>82</b> , to <b>11 NOV.</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11 Nov.</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Shailesh Kadakia</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shailesh Kadakia, M.D., CPT, MC</b>				22e. ADDRESS <b>Kimbrough Army Community Hospital/Ft. Meade</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Linden-Lithicum Cem.</b>		23d. LOCATION CITY OR TOWN <b>Clarksville</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>FLECK FUNERAL HOME, INC.</b> ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Dietrich</b>	

RECEIVED  
FEBRUARY 27 1961  
U.S. AIR FORCE

November 11 1955

Alameda

Alameda

Alameda County

Alameda County

Alameda County Hospital

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Alameda County Hospital

Alameda County

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Alameda County Hospital - right lower lobe pneumonia

Alameda

Alameda



Alameda County Hospital - right lower lobe pneumonia

NOV 11 1955

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 6 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rita Agnes Doggendorf				2a. DATE OF DEATH MONTH DAY YEAR November 11, 1982			
3. SEX Female				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1917	
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7a. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Clearwater Beach				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8109 Holly Road (21226)			
13a. STATE Maryland				13b. COUNTY A. A.		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST William L. Huber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret A. LaMarr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213 36 4272		17. INFORMANT ADDRESS Max Joseph Doggendorf, 8109 Holly Rd., Baltimore, Md. 21226	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>82</u> , to <u>Nov</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Nov 7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE PKomis				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PKomis				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, '82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A.Co., Maryland	
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR NOV 16 1982		25b. REGISTRAR'S SIGNATURE John J. Carver	

MEDICAL CERTIFICATION



100% COTTON FIBER



MADE IN GERMANY

VON



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 7 7 6 5  
REG. NO. EST

1. DECEASED NAME (TYPE OR PRINT) KATHRYN MARGARET DOUGHERTY			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1982			2b. HOUR P 10:18 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 18 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service	
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward H. Dougherty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Medlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-4504		17. INFORMANT Brother Edward H. Dougherty, Same as 13			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Lung Carcinoma</u> (c) <u>Liver Metastasis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>14y pericardial Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>Nov 26 1982</u> to <u>Nov 29 1982</u> , that (1) (we) lost <u>James</u> above, (1) two (three) did not view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (OR PRINT) BENITO MARTINEZ, M. D.		22e. ADDRESS 2932-A MOUNTAIN ROAD PASADENA, MARYLAND 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2 Dec 82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD					
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR DEC 3 - 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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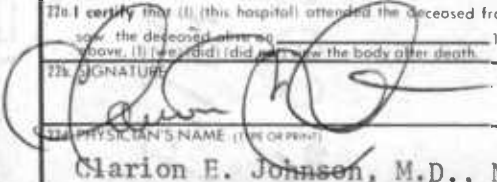
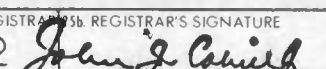
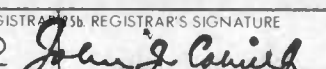
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 6 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alexander Raymond Dowgwillo</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>November 14 82 7:00pm</b>			
3. SEX <b>Male</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 24 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>65</b> MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Ft. Meade, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kimbrough Army Community Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Army</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A. A.</b>		13c. CITY OR TOWN <b>Crownsville</b>	
14. FATHER'S NAME <b>Hipolit</b>				15. MOTHER'S MAIDEN NAME <b>Mary A. Saworska</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW=2 164-05-4023</b>		17. INFORMANT ADDRESS <b>Joanne Dowgwillo/1425 Hoppa Road/Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial Infarct</b> (b) } (c) <b>Atherosclerotic heart disease</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clarion E. Johnson, M.D., MAJ, MC</b>				22e. ADDRESS <b>Kimbrough Army Community Hospital, Ft. Meade, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/18/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lady of The Fields</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Millersville A. A. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond C. Fink</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>			
25b. REGISTRAR'S SIGNATURE 				25c. REGISTRAR'S SIGNATURE 			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 6 7  
E.S.T.

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
SHEPHERD DRAIN III			NOVEMBER 16, 1982			5:29 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	WHITE	MAY 14 1930	52 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
MARYLAND	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		SALES MANAGER			D.M. DISTRIBUTOR		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS		
MARYLAND			ANNE ARUNDEL			SEVERNA PARK		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
SHEPHERD DRAIN			DOROTHY CONSER			212-30-1794		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. INFORMANT			17c. ADDRESS		
NO			BETTY J. DRAIN			(SAME AS 13)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LOST.

(b) 4100

DUE TO, OR AS A CONSEQUENCE OF

(c) 4100

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> 19 <u>82</u> to <u>Nov 16</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Nov 16</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>Max C. Frank</u> DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/16/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C. FRANK, M. D.		22e. ADDRESS MARYLAND 21061 7575 RITCHIE HIGHWAY, SOUTHEAST, GLEN BURNIE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	Nov. 17, 1982	WESTVIEW CREMATORY	WESTVIEW BALTIMORE MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
ROBERT S. BARRANCO		NOV 18 1982	
501 RITCHIE HWY SEVERNA PARK, MD		REGISTRAR'S SIGNATURE <u>John J. Canine</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP





BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27168	
1. DECEASED NAME (TYPE OR PRINT) M. Louise DYER						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11-21-82		7b. HOUR M 11:30			
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12/14/99	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 11-21-82		7d. HOUR 11:30				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 239 Bay Front Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY A. A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 239 Bay Front Dr. 21122			
14. FATHER'S NAME FIRST MIDDLE LAST Solomon German				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Harrington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216 46 3630		17. INFORMANT ADDRESS Albert Beehler, Jr., Balto., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 Gunshot wound of chest (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 11-21-82 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN PASADENA, COUNTY Maryland STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margaret McKell		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 11-22-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN Balto.,		COUNTY STATE MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

MEMORANDUM

OFFICE OF THE SECRETARY OF DEFENSE

TO : The Secretary of Defense  
FROM : Mr. [Name]  
SUBJECT: [Subject]  
DATE: [Date]  
1. [Text]  
2. [Text]  
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OFFICE OF THE SECRETARY OF DEFENSE

1000 York Road, Baltimore, MD 21101  
John W. Johnson & Son, Inc.  
Burlingame, CA 94010  
MD

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 7 1 6 9  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA J. EASTON</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>26</b> YEAR <b>82</b> 2b. HOUR <b>7:06 P.M.</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH <b>07</b> DAY <b>09</b> YEAR <b>36</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>ARNOLD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1363 Shirleyville Rd.</b>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b></b> LAST <b>HARRIS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNIE</b> MIDDLE <b></b> LAST <b>NEAL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-34-9765</b>		17. INFORMANT <b>DANIEL EASTON</b> ADDRESS <b>Arnold, Md. 1363 Shirleyville Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>H. Goldstein, M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Goldstein, M.D.</b>				22e. ADDRESS <b>205 Ridgely Ave, Annap.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-30-92</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER CHURCH CEME.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Galesville A.A. Maryland</b>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <b>NOV 30 1982 John J. Conish</b>			
24. FUNERAL DIRECTOR NAME <b>Annapolis, Md.</b> <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>					

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE  
WASHINGTON, D. C.

NAME	DATE	TIME	PLACE	REMARKS
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
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JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital

NAME	DATE	TIME	PLACE	REMARKS
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital
JOHN J. HARRIS	10-10-44	10:00	ST. LOUIS	Admitted to hospital

NOV 30 1944  
J. J. Harris

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 7 0

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Norman Douglas Edmondson			2a. DATE OF DEATH MONTH DAY YEAR November 3, 1982		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH Severn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8285 Sebring Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY E.G. & E.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN Severn			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Hurren Edmondson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Dooms		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean 219.30.8988		17. INFORMANT -wife- ADDRESS same as # 13 Kathleen R. Edmondson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SQUAMOUS CELL CA. 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) OF LUW6 DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
I hereby certify that (I) this hospital attended the deceased from August 24, 1982 to November 3, 1982, that (I) (we) last saw the deceased alive on November 3, 1982, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) (saw) the body after death.					
21g. SIGNATURE Dr. Diana H. Griffiths		DEGREE MD		22c. DATE SIGNED 11/4/82	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Diana H. Griffiths		22b. ADDRESS Medical Oncology, St. Agnes Hosp., 900 Caton Ave. Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6 Nov 1982	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. MD
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 5 1982		25b. DATE 15 DAYS AFTER DEATH 11/18/82	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION



RECEIVED

1951

1951

1951

1951



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 7 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lula Ellen Ellison</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 2, 1982</i>		2b. HOUR <i>Approx 9:15a M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 28, 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Anundel Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Abraham Reed</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maggie White</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-70-2815</i>		17. INFORMANT ADDRESS <i>Mr. Samuel P. Ellison Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular insufficiency</i> 7 years. DUE TO, OR AS A CONSEQUENCE OF (c) <i>diabetes mellitus</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>2/8 1960 11/2 82</i>			
22a. I certify that (I) (we) attended the deceased from <i>11/1 1982</i> to <i>11/2 1982</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>11/1 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <i>R.M. McLaughlin</i> M.D.				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/4/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Randall Mc Laughlin, M.D.</i>				22e. ADDRESS <i>3708 Mountain Rd., Pasadena, Md. 21122</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 5, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Anne Arundel</i>	
24. FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home of Pasadena</i>				25a. DATE RECEIVED BY REGISTRAR <i>NOV 5 1982</i>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 2			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Andrew J. Fabula</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 82</b>		2b. HOUR M <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Brooklyn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>109 10th Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Rigger</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Ship bldg.</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Brooklyn</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>109 10th Ave. (21225)</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Fabula</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Ciris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-14-5082</b>		17. INFORMANT ADDRESS <b>Joseph Fabula 3622 Bonview Ave. (21213)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) CARDIOPULMONARY arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary artery disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate hours years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>cerebrovascular accident - urinary tract infection + sepsis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 17</b> , 19 <b>81</b> , to <b>Oct 5</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Oct 5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J.E. Kaplan, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/26/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.E. KAPLAN, M.D.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>11/27/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 1 - 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of a case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 7 3			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>Gladys S. Fanning</b>				MONTH DAY YEAR <b>11/23/82</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH		2b. HOUR <b>3:40 A.M.</b>	
MONTH DAY YEAR <b>JUNE 7, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MONTHS DAYS <b>87 YRS.</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>HARWOOD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH L. SHIPLEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SANNIE - STEFFE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213-56-7701</b>		17. INFORMANT <b>MR. WALLACE R. FANNING JR. (SON)</b>	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4413 Ruptured Aorta, Aortic Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronicologic age of 87</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs - 5 yrs -</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Chronicologic age of 87</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>104 Forbes Street Annapolis, MD 21401</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22</b> , 19 <b>82</b> , to <b>11-23</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11-22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>Gay M. Richardson MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-23-82</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY M. RICHARDSON</b>				22e. ADDRESS <b>MD 104 Forbes Street Annapolis, MD 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 26, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD, P.G. CO. MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

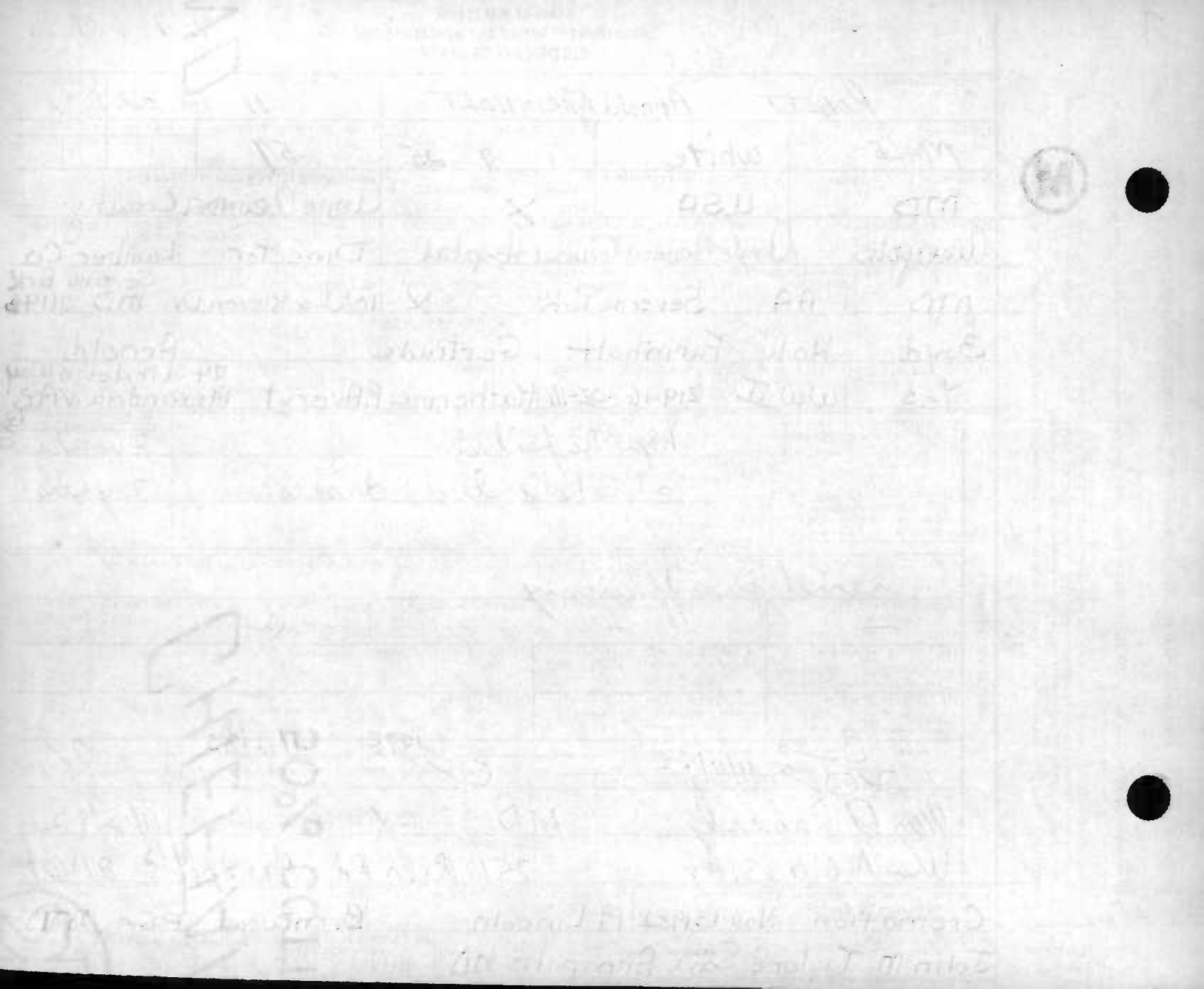
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT</b> <b>Arnold</b> <b>FARINHOLT</b>			2a. DATE OF DEATH		MONTH DAY YEAR <b>11 12 82</b>	
3. SEX <b>MALE</b>			4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 7 25</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
9. CITY OR TOWN OF DEATH <b>Annapolis</b>			10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MD</b>			12b. CITY OR TOWN <b>Beverna Park</b>		12c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME FIRST MIDDLE LAST <b>Boyd</b> <b>Haly</b> <b>Farinholt</b>			14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude</b> <b>Arnold</b>		15. STREET ADDRESS <b>Severna Park 102 Lockleven Dr. MD 21146</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>1WW II 219-16-0296</b>		17. INFORMANT <b>Katherine F. Avery</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic failure</b> <b>5713</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>alcoholic liver disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>renal insufficiency</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>7 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>renal insufficiency</b>						
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>19 1976</b> to <b>11/12/82</b> 19 <b>—</b> that (1) (we) lost saw the deceased alive on <b>11/11/82</b> 19 <b>—</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.						
22b. SIGNATURE <b>Wm A Cassidy</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm A Cassidy</b>		22e. ADDRESS <b>2510 Riva Rd Annapolis 21401</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov 13, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG 21155</b>
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons, Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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## Medical Examiner notified &amp; released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 7 1 7 5	
1 - FOR STATE REGISTRAR			CERTIFICATE OF DEATH				REG. NO.		EST		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		A M	
BOBBY JAMES FLEMING, SR.			NOVEMBER 5, 1982		8:35						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 30, 1933		49 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Alabama		U.S.A.				ANNE ARUNDEL COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Mechanic-Foreman		Paper Cup Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		Zip Code - 21061	
Maryland		Anne Arundel		Glen Burnie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		441 Elwell Court			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Herman Clyde Fleming				Eunice Townley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Address Same as No# 13e.	
No				212-44-9685		Mrs. Shirley E. Fleming					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hypotension</u>										3 Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI Bleeding</u>										8 Hours	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CH of Esophagus - Advanced</u>										2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WOUND <input type="checkbox"/> AS WOUND <input type="checkbox"/> NOT WOUND <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> to <u>11/8</u> , 19 <u>82</u> ; that (I) (we) last saw the deceased on or about <u>11/5</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
<u>David A. Schwartz</u>										11/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS	
DAVID A. SCHWARTZ, D.O.										7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Nov. 8, 1982		Ft. Lincoln Cemetery		Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						NOV 9 1982		<u>F. Gasch</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DIRECTOR, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 7 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Sean T. Fournier				2a. DATE OF DEATH MONTH DAY YEAR 11 24 1982			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 14 1973		6. AGE (IN YEARS LAST BIRTHDAY) 9	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Brooklyn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 224 Creswell Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ===		12b. KIND OF BUSINESS OR INDUSTRY ===	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY A.A.		13c. CITY OR TOWN Brooklyn	
14. FATHER'S NAME FIRST MIDDLE LAST James R. Fournier				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Donna J. Geoghan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. ===		17. INFORMANT ADDRESS James Fournier (same as 13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hurlers Syndrome ( lipochondra dystrophy)</u> 2775 DUE TO, OR AS A CONSEQUENCE OF (b) <u>with obstructive hydrocephalus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Bae M.D.				22c. ADDRESS 606 Hammonds Lane Balto. Md. 21225		22d. DATE SIGNED 11/26/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Bae M.D.				22f. ADDRESS 606 Hammonds Lane Balto. Md. 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/26/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hgwy.				25. DATE REC'D. BY REGISTRAR NOV 26 1982			
26. REGISTRAR'S SIGNATURE John J. Gance				27. REGISTRAR'S SIGNATURE John J. Gance			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 2 7 7 7 7									
FOR STATE REGISTRAR					REG. NO.									
CERTIFICATE OF DEATH					EST									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
FIRST MIDDLE LAST <b>ALEXANDER (nmn) FOY</b>					<b>NOVEMBER 3, 1982</b>					<b>10:35 P</b>				
3. SEX <b>Male</b>					4. RACE <b>White</b>					5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 13, 1907</b>				
6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR					8. IF UNDER 24 HRS.				
<b>74</b>					<b>MONTHS</b>					<b>DAYS</b>				
7a. BIRTHPLACE (STATE OR FOREIGN) <b>North Carolina</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>									
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Arundel</b>					13c. CITY OR TOWN <b>Severn</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rufus R. Foy</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Hawkins</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>Dec. 2, 29</b> <b>Dec. 24, 30</b>					17. INFORMANT (wife) ADDRESS <b>Mrs. Helen L. Foy Same as # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Heart Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHF - Chronic</b>														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/17/82</b> 19 to <b>11/3/82</b> 19 that (I) (we) last saw the deceased alive on <b>11/3/82</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)														
22b. SIGNATURE <b>Jorge B. Ramirez</b>										22c. DATE SIGNED <b>11/4/82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE B. RAMIREZ, M.D.</b>										22e. ADDRESS <b>7845 Oakwood Road #205 Glen Burnie, Maryland 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>Nov. 6, 1982</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>				
24. FUNERAL DIRECTOR NAME <b>R. H. Hopkins</b>					24b. ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1982</b>				
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>														

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Handwritten text, possibly a signature or date, in the center of the page.

Handwritten text at the bottom of the page, including what appears to be a date "11/1/05" on the left and a large circled mark on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 7 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Gertaude A FRANTOM</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-8-82</b>		2b. HOUR <b>8:25</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 06 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Annapolis Conv. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b> 13c. COUNTY <b>AA</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Bay Ridge Ave &amp; Van Buren St</b> <b>21403</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Y.</b> LAST <b>Hall, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lottie</b> MIDDLE <b>Van Pelt</b>		16. ADDRESS <b>Regina F. Rawlings 1207 Balt. Ann. Blvd. Arnold MD 21012</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Regina F. Rawlings</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Acc.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ce of heart.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION <b>11/9/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/7/82</b> to <b>11/8/82</b> , that (I) (we) last saw the deceased alive on <b>11/8/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) visit the body after death.							
22b. SIGNATURE <b>R. Brumfield</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 11, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arnold Asbury</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arnold AA MD</b>	
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons - Annapolis, MD</b>		ADDRESS		25a. DATE REG'D. BY REGISTRAR <b>NOV 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

dm

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BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
1. DECEASED NAME TYPE FIRST MIDDLE LAST Anna H. Galligan						2a. DATE OF DEATH MONTH DAY YEAR 11-14-82		2b. HOUR 1:45 PM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 10, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living N. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Accountant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 113 Kingswood Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Galligan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Riley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 021-01-9521		17. INFORMANT ADDRESS Charles Galligan, 113 Kingswood Rd., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>1739</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Skin Cancers</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seventy years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>10-28</u> , 19 <u>82</u> , to <u>11-14-82</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>11-12</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (old not) view the body after death.									
22b. SIGNATURE <u>Charles W. Kinzer, M.D.</u> DEGREE						22c. DATE SIGNED <u>11-14-82</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer				22e. ADDRESS <u>16 Murray Ave. Annapolis Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/18/82		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE West Roxbury, Mass.			
24. FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home 1212 West St., Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR NOV 18 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			

1212 West St., Annapolis, Md.  
Beall Funeral Home

Burial 11/17/82 St. Joseph Cem. West Roxbury, Mass.

Charles W. Kinzel



200  
COPIES

no

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John Henry Golligan  
Annapolis, Md.  
1021-71-1521 Charles Golligan, 112 Kinsey St., Annapolis, Md.

Mary Jane A.A. Annapolis

112 Kinsey St.

Engelhardt Pleasant Living N. Home  
Retired Accountant

Mass. U.S.A.

Anne Arnold

Female

Jan. 10, 1882

90



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 1 8 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>Adelene Marie Ganter</b>				MONTH DAY YEAR HOUR <b>November 11, 1982 9:35 M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Conv. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>4 Carnene Drive</b>		13f. CITY OR TOWN <b>(21122)</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip Sacht</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Moon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>n/a</b>		17. INFORMANT (Husband) ADDRESS same as # 13 <b>Mr. Carl F.W. Ganter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>arthritis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-11-82</b> to <b>11-11-82</b> , that (I) (we) last saw the deceased alive on <b>11-11-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mustafa C Ozur</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-11-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mustafa C Ozur</b>				22e. ADDRESS <b>605 BXA Blvd Severna Park</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 15, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Dean P. Charlton</b>		ADDRESS <b>Glen Burnie MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	



RECEIVED  
JAN 11 1964  
U.S. AIR FORCE  
HARRISBURG, PA.

HARRISBURG, PA.

APR 11 1964

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Items #1a-22a Film G575 1/12/83 rSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 2 7 7 8 1

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Steven Patrick Garriss			11 21 19 82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	Oct. 18, 1949	33 YRS.			11 22 19 82	1:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Indiana		U.S.A.				Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie		318 apt 1-4 Highland Drive				BM2		U.S.C.G.
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
North Carolina			Onslow Co.		Jacksonville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS		
Rhyne E. Garriss			Louise - Peele			792 River Court		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Yes		Active Duty		240-86-8707		Rhyne Garriss/Father/Same as # 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia from hanging by neck</u> 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED				
		Est. HOUR A.M. MONTH DAY YEAR ? P.M. 11/21/82		found hanging				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE		
		Home		318 Apt. T-4 Highland Dr. Glen Burnie AA Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Industrial causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED
<i>H.R. Guard</i>		Assistant						11/23/82
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hormez R. Guard, M.D.		111 Penn Street, Balto., MD 21201				<i>James J. Connel</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Nov/29/82		Onslow Memorial Park		JACKSONVILLE, ONSLOW, N.C.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Chambers Funeral Home				DEC 1 1982		<i>James J. Connel</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.

1. **Subject:** [Illegible]  
2. **Reference:** [Illegible]  
3. **Summary:** [Illegible]  
4. **Details:** [Illegible]  
5. **Recommendation:** [Illegible]  
6. **Remarks:** [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 7 7 8 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine C. Gibson</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 21, 1982</i>		2b. HOUR <i>A</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 16 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN TRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Annapolis Convalescent Home</i>				12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Pub. Schools</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>13a. COUNTY <i>A.A.</i> 13b. CITY OR TOWN <i>Annapolis</i> 13c. CITY OR TOWN <i>21403</i></i>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>105 Maple Lane</i>			
14. FATHER'S NAME <i>Wm Scott</i> MIDDLE LAST				15. MOTHER'S MAIDEN NAME <i>Mary Ewing</i> FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>193-03-1468</i>		17. INFORMANT <i>Wm M. Gibson</i> ADDRESS <i>#13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7140 INANITION DUE TO (b)</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatoid arthritis - severe</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
9a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles W. Kinzer</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11-22-82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES W. KINZER, M.D.</i>				22e. ADDRESS <i>16 MURRAY AVE. ANNAPOLIS, MD 21401</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>				23b. DATE <i>11-22-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		23d. LOCATION CITY OR TOWN <i>Brentwood P.G. Md.</i>			
24. FUNERAL DIRECTOR <i>John M. Layton Sons</i> ADDRESS <i>Annapolis, Md.</i>				25a. DATE REC'D BY REGISTRAR <i>NOV 24 1982</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 7 8 3		EST	
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPHINE GIGLIOTTI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 20, 1982</b>		2b. HOUR P. <b>1:05 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 01 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>92</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND BALTIMORE ROSEDALE</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAM -----</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY GRACE -----</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216469832</b>		17. INFORMANT ADDRESS <b>ROSIE DUFFY 2015 SUMMIT AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural Causes</b> <b>7999</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Cybernetic of the heart</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/27</b> , 19 <b>82</b> , to <b>11/20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert B. Kroopnick</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/20/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>				22e. ADDRESS <b>205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland, 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION CITY OR TOWN COUNTY <b>BALTIMORE 2. County</b>	
24. FUNERAL DIRECTOR NAME <b>John Coal</b>				ADDRESS <b>1211 Chesapeake Ave.</b>		25. DATE RECEIVED BY REGISTRAR <b>NOV 22 1982</b>	

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3. But in the case of the *Staphylococcus aureus* bacterium, the researchers found that the bacteria were able to adapt to the presence of the antibiotic.

1812 West Street, San Jose, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alice E. Good</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 22 82</b>			2b. HOUR <b>M</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>124 Southbridge Drive, Apt.J</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Dekowski</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Sasse</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-24-0329</b>		17. INFORMANT <b>124 Southbridge Dr. Apt.J Melvin D. Good-Glen Burnie, MD. 21061</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Lung Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Eric Fisher</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/22/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Eric Fisher</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/24/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				



Handwritten text, possibly a title or subject, in cursive script.



NOV 2 1905

LIBRARY OF THE UNIVERSITY OF MICHIGAN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
ANN MARIE GOVEART			11 9 1982			A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. UNDER 1 YR.	7c. DATE PRONOUNCED DEAD	2d. HOUR		
F	W	8 19 47	35 YRS.		11 9 1982	7		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7d. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
WASH. D.C.			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Edgewater			235 Edgewater K. DR			ACCOUNTANT		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
VA. Alexandria			Alexandria			P.O. Box 7085		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
ALFRED JOSEPH GOVEART			LOIS IRENE CAPPS			577-64-5051		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?			17b. INFORMANT			17c. ADDRESS		
No			Lois Goveart			2600 KEATING ST Temple Hills, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1 DEATH WAS CAUSED BY:								
9554 IMMEDIATE CAUSE (a) Gunshot wound - knee								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost:								
DUE TO, OR AS A CONSEQUENCE OF								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR			P.M. 11 9 1982		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
			Home			CITY OR TOWN COUNTY STATE		
						A.A.C.O. MD		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
22b. ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
E. Linhardt			M.D. Deputy			11.10.82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
E. LINHARDT			Annapolis - MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
CREMATION			11-13-82			Cedar Hill Cemetery		
24. FUNERAL DIRECTOR			25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE		
NAME ROBT E Wilhelm FUN. Home			ADDRESS 4308 SUTLAND RD			NOV 16 1982		

MEDICAL CERTIFICATION

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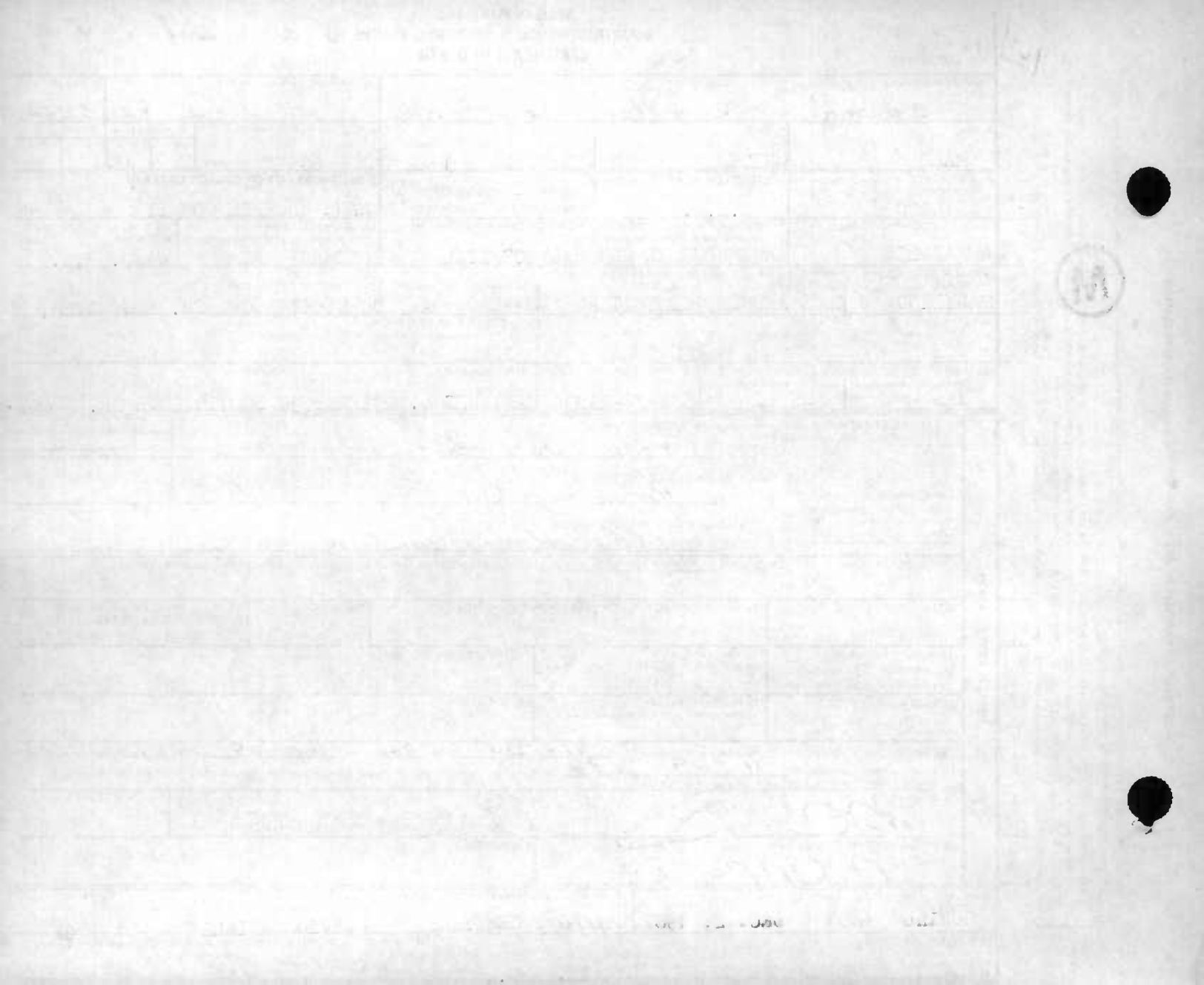
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 7 8 7			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edward D. Grimley Sr.				2a. DATE OF DEATH MONTH DAY YEAR 11-29-82			
3. SEX MALE				4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 20 1922	
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH ANNAPOLIS	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY WASH. R.R.	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN EDGEWATER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GRIMLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE HAYES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS MARGARET E. GRIMLEY 90 SCOTTS COVE RD. EDGEW.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Refractory CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>82</u> , to <u>11-29</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>11-29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>HA</u> DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A CAPUTO				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 2, 1982		23c. NAME OF CEMETERY OR CREMATORY LAKEMONT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE MD.	
24. FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN., MD				25a. DATE REC'D. BY REGISTRAR NOV 30 1982			
25b. REGISTRAR'S SIGNATURE							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 7 1 8 8  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS EUGENE GRISCOM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 22 1982</b>			2b. HOUR <b>AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 10 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
12. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNAPOLIS NURS. CONV. CTR.</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CIVIL SERVICE</b>		15. KIND OF BUSINESS OR INDUSTRY <b>45 GOV'T</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b>				17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS <b>410 SEVERN AVE 21403</b>			
19. FATHER'S NAME (FIRST) MIDDLE LAST <b>FERDINAND GRISCOM</b>				20. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST <b>ANNIE BREWER</b>					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				22. SOCIAL SECURITY NO. <b>218129481M</b>		23. INFORMANT <b>ARLEVIN ROBERTS TUCSON ARIZONA</b> <b>6941 NO CAMINO DE FOSBERO 85718</b>			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Failure</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that (I) (the hospital) attended the deceased from <b>5/8</b> 19 <b>79</b> to <b>11/22</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
36. SIGNATURE <b>Richard I. Hochman</b>						37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED <b>11/23/82</b>	
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard I. Hochman</b>			40. ADDRESS <b>16 Murray Ave. Annapolis, MD 21401</b>						
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			42. DATE <b>11-23-82</b>		43. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREM.</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD P.G. MD.</b>		
45. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel Annapolis MD</b>			46. ADDRESS <b>21401</b>		47. DATE REC'D. BY REGISTRAR <b>NOV 24 1982</b>				
48. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 8 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FRANCES Estelle GYORDA			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 3, 1982			2b. HOUR P M 8:30 A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 24, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY A. A.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Crownsville State Hospital		
14. FATHER'S NAME FIRST MIDDLE LAST U N K N O W N				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia = Conrad						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 183-12-4305-A		17. INFORMANT ADDRESS John Gyorda R.R. -4- Box 4287 La Plata. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis, renal failure</i> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF, Acute resp. failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>aspirin</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/27</i> , 19 <i>82</i> , to <i>11/3</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>H. T. Towidian, M.D.</i>					DEGREE M.D.		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID A. TOWIDIAN, M.D.					22e. ADDRESS 3236 Mountain Road Pasadena, Maryland 21122					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/6/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Family Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Troop, Penna.				
24. FUNERAL DIRECTOR NAME Raymond C. Fink					ADDRESS Glen Burnie, Md		25a. DATE REC'D. BY REGISTRAR NOV 4 1982		25b. REGISTRAR'S SIGNATURE <i>Sam J. Gail</i>	

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

[illegible]

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

22101230 2nd Unit

RECEIVED

UNIT 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
Leonard N. Harris, SR.								11 11 1982				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE	BLACK	5 19 1939		43 YRS.						11 11 1982		8:00 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.				Anne Arundel County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Galesville		956 Benning Road											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND		A.A.		GLAESVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>		956 Benning Rd.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
JOSEPH		ANNIE		NO				LORETTA HARRIS		Galesville, Md.			
								956 Benning Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Shotgun wound of Chest & Abdomen													
DUETO, OR AS A CONSEQUENCE OF													
(b)													
DUETO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY (approx.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		2:00 PM 11 11 1982		subject was shot									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
		Home		956 Benning Road		Galesville		Anne Arundel Co.,		Md.			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Ann M. Dixon, M.D.		M.D. Assistant		11-12-82									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
BURIAL		11-16-1982		EBENEZER CHURCH CEME.		Galesville		A.A.		Maryland			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md.				NOV 16 1982		John J. Conner					



UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315





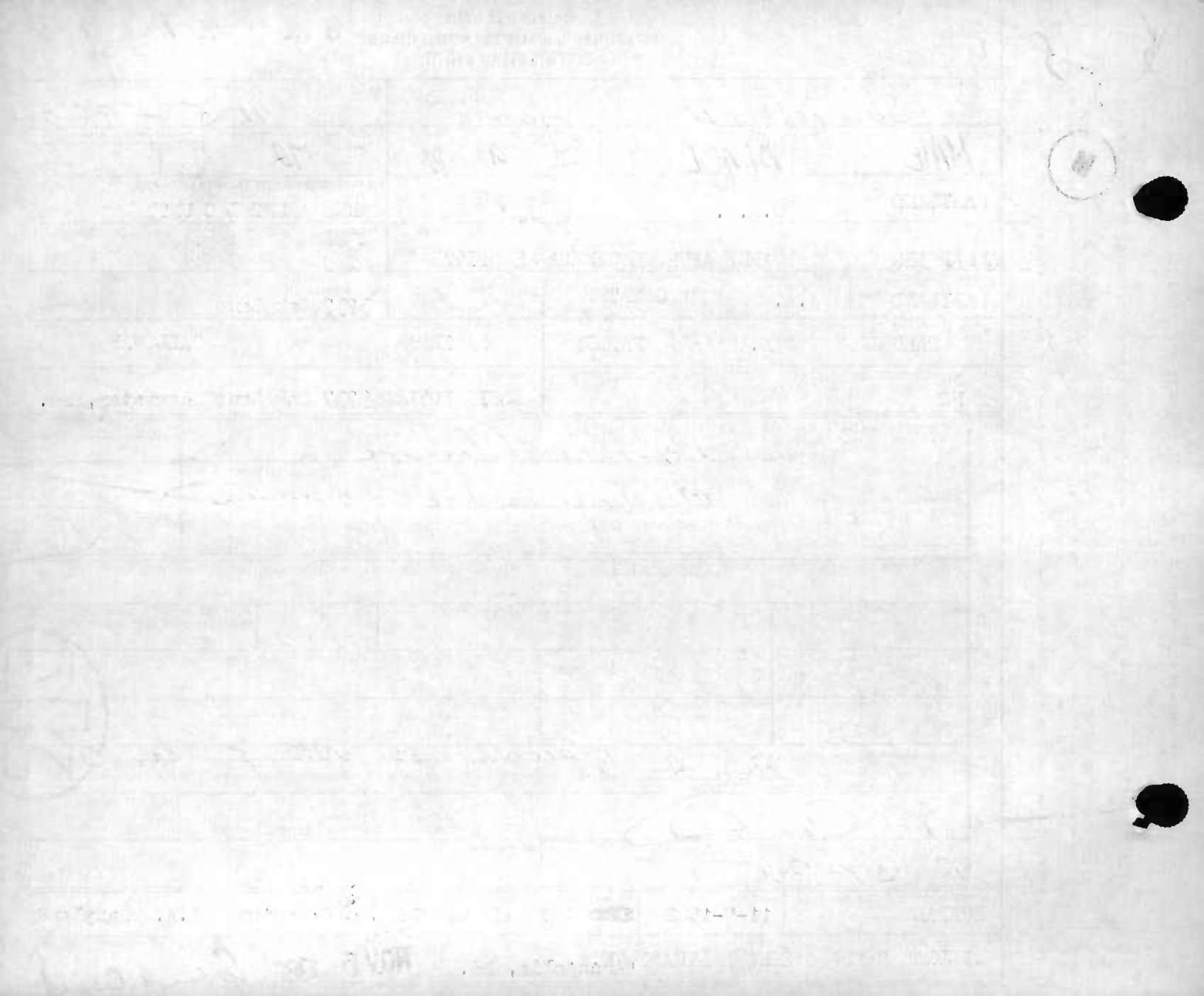
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 2 7 1 9 2	
1. FOR STATE REGISTRAR						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Samuel H. Harris</u>				2a. DATE OF DEATH MONTH <u>11</u> DAY <u>5</u> YEAR <u>82</u>		2b. HOUR <u>7:55 A.M.</u>	
3. SEX <u>MALE</u>		4. RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH <u>2</u> DAY <u>9</u> YEAR <u>10</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL COUNTY</u> MD.	
10. CITY OR TOWN OF DEATH <u>ANNAPOLIS</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>A.A.</u>		13c. CITY OR TOWN <u>EDGEWATER</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <u>SAMUEL</u> MIDDLE <u>H.</u> LAST <u>HARRIS</u>				15. MOTHER'S MAIDEN NAME <u>MARINDA</u> MIDDLE <u>GALLOWAY</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>ELSIE BUTLER</u> ADDRESS <u>3737 Oak Lane Edgewater, Md.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-renal Failure</u> <u>1519</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic gastric carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>March 19 82</u> to <u>Nov. 5 19 82</u> , that (1) (we) last saw the deceased alive on <u>Nov. 4 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Caputo</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. CAPUTO</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>11-9-1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOPE CHURCH CEME.</u>		23d. LOCATION <u>Edgewater A.A. Maryland</u>	
24. FUNERAL DIRECTOR <u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 5 1982</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Connel</u>	



BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ruth E. HARRISON</b>				2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 10 1982</b>				2b. HOUR M <b>12</b>			
3. SEX <b>F</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 5 1922</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>60 YRS.</b>		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b>				10. CITY OR TOWN OF DEATH <b>Glenn Burnie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>North Arundel Hospital</b>			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>				13a. COUNTY <b>A.A.</b>		13b. CITY OR TOWN <b>ODENTON</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY CONWAY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIA GALLOWAY</b>				16. STREET ADDRESS <b>624 Waugh Chapel Road</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				17b. SOCIAL SECURITY NO. <b>579-48-5122</b>		17. INFORMANT ADDRESS <b>PETER HARRISON 624 Waugh Chapel Rd. Odenton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) M.D. <b>Deputy</b>				MEDICAL EXAMINER DATE SIGNED <b>11-10-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-15-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia U.M. CHURCH</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Odenton A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILLIAM REESE &amp; SONS MORTUARY, P.A. Annapolis, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 7 9 4			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Laurence Edward Holden</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 15, 1982</b>		2b. HOUR <b>2:37 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 3, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>S.G.M.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry - Holden</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna C. Reagan</b>		13e. STREET ADDRESS <b>7953 Elvaton Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Active Duty 216-32-5306</b>		17. INFORMANT ADDRESS <b>Friederike Holden (Wife) Same as # 13.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>A.R.D.S. due to hemorrhagic pancreatitis</b> <b>5185</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>11/14/82</b> , 19 <b>82</b> , to <b>11/15</b> , 19 <b>82</b> , that (b) (I) saw the deceased alive on <b>11/15</b> , 19 <b>82</b> , and that in my opinion death occurred on the date and hour and from the causes stated above (c) (I did not) view the body after death.							
22b. SIGNATURE <b>Recep Erol</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Recep Erol, M.D.</b>				22e. ADDRESS <b>325 Hospital Dr. #104 Glen Burnie, Md. 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1982</b>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
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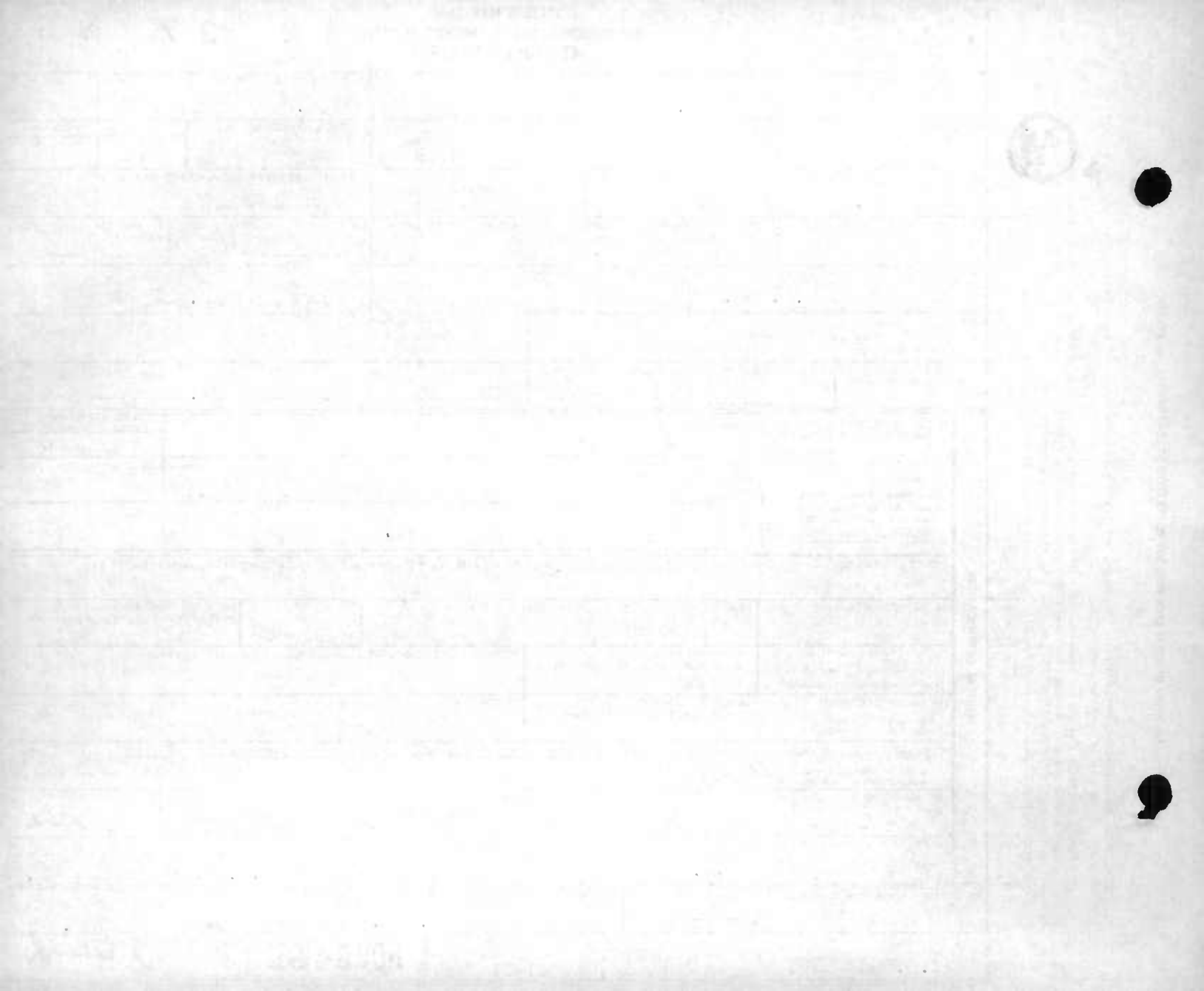
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SILAS D. HOLLAND			2a. DATE OF DEATH MONTH DAY YEAR NOV. 23, 1982			2b. HOUR M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 15 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BERLIN MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD				
10. CITY OR TOWN OF DEATH HANOVER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7657 RIDGE RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PIPE FITTER		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY A.A. CO.		13c. CITY OR TOWN HANOVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 84% RIDGE RD. 20794	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES HOLLAND			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ENNIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-07-4773		17. INFORMANT ADDRESS 20794 MARY HOLLAND 7657 RIDGE RD. HANOVER MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart heart failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.I.C.V.D.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-24-82</u> to <u>11-19-82</u> 19____, that (I) (we) lost saw the deceased alive on <u>11-19-82</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert Dabolins M.D.</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT DABOLINS M.D.						22e. ADDRESS 400 CRAIN HIGHWAY N.W. GLEN BURNIE, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-26-82		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MD.			
24. FUNERAL DIRECTOR NAME T.A. HARDESTY ADDRESS ANNAPOLIS, MD 21401						25a. DATE REC'D BY REGISTRAR NOV 24 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
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REGISTRAR

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DUNCAN Cameron Horne, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 21, 1982</b>		2b. HOUR P. <b>2:00 M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 3 27</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. UNDER 24 HRS. HOURS MIN. <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY, MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maint. Man</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lion Bro. Inc.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1121 Cedar Cliff Dr. 21061</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Duncan C. Horne, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Zell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-22-1931</b>		17. INFORMANT ADDRESS <b>Duncan C. Horne, III 19 Brookbury Dr. 21136</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>Nov. 16</b> , 19 <b>82</b> , to <b>Nov. 21</b> , 19 <b>82</b> , that (2) (we) last saw the deceased alive on <b>Nov. 21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Charles J. Wu, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Nov. 21, 1982</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES J. WU, M.D.</b>		22e. ADDRESS <b>7845 Oakwood Road, #204 Glen Burnie, Maryland, 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/24/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>						
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue</b>		25a. DATE REGD. BY REGISTRAR <b>NOV 24 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 7 7 9 7  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR			REG. NO.		EST
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
ERSIE D. HORNEY			NOVEMBER 10, 1982		6:50P <sup>M</sup>
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
Female	White	7/12/1917	65 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Housewife		Domestic
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	A.A. Co.	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1621 Tieman Drive, 21061	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
John Dolch			Bessie Schwartz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		
no			219-05-6688		
17. INFORMANT			ADDRESS		
Edward F. Horney, Sr.			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Myocardial Infarction					Days
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease					years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-7-82 to 11-10-82 that (I) (we) last saw the deceased alive on 11-8-82 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
[Signature]				11-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JACK I. STERN, M.D.		300 HOSPITAL DRIVE #135 GLEN BURNIE, MD. 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Burial		11/13/1982	Glen Haven Mem. Pk.	Glen Burnie, A.A. Co., Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McCully Funeral Homes		NOV 12 1982		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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57411



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 7 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>ESTELLE HORSEMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 12, 1982</b>			2b. HOUR P. <b>10:55 M.</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 8 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY, MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Anne Arundel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219 54 3593</b>		17. INFORMANT ADDRESS <b>Brenda Watson 7355 Furance Branch Rd.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>586</b> <b>586</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Always</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

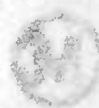
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> , 19 <b>82</b> , to <b>11/12</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. T. Towhidian</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAMID A. TOWHIDIAN, M.D.</b>				22e. ADDRESS <b>3236 Mountain Road Pasadena, Maryland, 21122</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>11/17/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett 4600 Liberty Hgts. Ave.</b>					25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <b>NOV 17 1982 John J. Connel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Items #10&11 Film G574 12/17/82 r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH		DAY		YEAR		2b. HOUR	
WILLIAM B. HOWKINS, Jr.								11-15-82		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	6 26 60		22 YRS.						11-15-82		19				2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Mississippi		U.S.A.				Anne Arundel County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Linthicum		Anne Arundel Co. Hospital		Unemployed		---											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Anne Arundel		Linthicum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		435 Cleveland Road								21090	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William B. Howkins, Sr.		Virginia B. Bates															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		39564 Ocean Springs, Ms.											
YES		1978-1982		425-96-1733		William B. Howkins, Sr. P.O. Box 192											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple injuries																	
8152																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				1:26 AM 11-15-82				driver of motorcycle/fixed object impact									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				street				Hammonds Ferry Rd. Linthicum, Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Margarita A. Korell, M.D.				M.D. Assistant				11-15-82									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Cremation				11/17/82				Loudon Park Crematory				Baltimore					
												COUNTY Maryland					
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Hubbard Funeral Home, Inc.				21229				NOV 17 1982				John J. Connel					
NAME				ADDRESS													
Hubbard Funeral Home, Inc.				4107 Wilkens Ave.													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



LIBRARY OF THE  
UNITED STATES  
DEPARTMENT OF  
COMMERCE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 0 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE MARY HUBER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 3, 1982</b>		2b. HOUR <b>3:00 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Kolar</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Daughter) ADDRESS <b>125 Midland Road Mrs. Mary H. Christopher Glen Burnie, Md.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> (c) <b>Coronary Artery Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-2-82</b> , 19____, to <b>11-3-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>11-3-82</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles R. Mac Donald MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-3-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES R. MAC DONALD, M.D.</b>				22e. ADDRESS <b>325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>November 6 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>R. Hange</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1982</b>			
Singleton Funeral Home, Glen Burnie, Md.				John J. Carter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1951

8:00

NOVEMBER 2, 1951

HURR

CATHERINE

WANE ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

GLENN BURNETT

1951

1951

1951

11-7-51

325 HOSPITAL DRIVE

CHARLES A. MAC DONALD, M.D.

GLENN BURNETT, M.D.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dolores L. Hughes			2a. DATE OF DEATH MONTH DAY YEAR 11/26/82			2b. HOUR 7 <sup>30</sup> A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.	
10. CITY OR TOWN OF DEATH Edgewater, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 627 Londontown Rd. 21037				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate	
13a. STATE Md.		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Leslie Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine G. DeBrogli		17. INFORMANT ADDRESS Denise Stanley Same as # 10-11			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS Denise Stanley Same as # 10-11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Co. Injury DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 11/26/82, 19, that (I) (we) lost saw the deceased alive on 11/1/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE Stacy P. Watkins		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WATKINS		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-28-82		23c. NAME OF CEMETERY OR CREMATORY woodfield		23d. LOCATION CITY OR TOWN COUNTY STATE Galesville AACo. Md.	
24. FUNERAL DIRECTOR NAME Hardesty F. H.		25. DATE REC'D. BY REGISTRAR NOV 30 1982		25. DATE REC'D. BY REGISTRAR SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

Handwritten notes at the top of the page, including the word "march" and some illegible scribbles.

Second section of handwritten notes, featuring a large, stylized scribble in the center that appears to be a mix of letters and symbols.

Third section of handwritten notes, containing a circular diagram with internal markings and various illegible scribbles.

Bottom section of handwritten notes, including a large, stylized scribble and some illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 2 7 8 0 2									
CERTIFICATE OF DEATH									
REG. NO.									
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>ALIAS (Huggins)</b>			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A M
			FIRST MIDDLE LAST <b>Margaret Ireland</b>			<b>11-09-1982</b>			<b>1:00</b> M
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
<b>female</b>		<b>white</b>		<b>8-03-1892</b>		<b>90</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<b>MARYLAND</b>		<b>U. S. A.</b>				<b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>ANNAPOLIS</b>		<b>ANNE ARUNDEL GENERAL HOSPITAL</b>				<b>Housewife</b>		<b>Home</b>	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>MARYLAND</b>			<b>ANNE ARUNDEL</b>		<b>ARNOLD</b>		<b>13e. STREET ADDRESS 130 SPOT CLUB RD. 21012</b>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
<b>UNKNOWN</b>					<b>EMMA THOMAS</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
<b>NO</b>			<b>216-01-9937-A</b>		<b>LESLIE T. HUGGINS (SAME AS 13)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <b>4360 Cerebral vascular accident</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			<b>P.M. 19</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>JULY 3</b> , 19 <b>73</b> , to <b>NOVEMBER 8</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not view the body after death).									
22b. SIGNATURE			DEGREE					22c. DATE SIGNED	
<b>Donald Hislop</b>								<b>11/9/82</b>	
22d. PHYSICIAN'S NAME (Type or Print)			22e. ADDRESS						
<b>DONALD HISLOP MD.</b>			<b>OWENS WAY AND ROBINSON RD. SEVERNA PARK, MD 21146</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
<b>BURIAL</b>			<b>Nov. 11, 1982</b>		<b>GLEN HAVEN CEMETERY</b>		<b>GLEN BURNIE ANNE ARUNDEL MD.</b>		
24. FUNERAL DIRECTOR NAME			25a. DATE OF REGISTRATION			25b. NAME OF REGISTRAR			
<b>ROBERT S. BARRANCO</b>			<b>5045 RITCHIE HWY. SEVERNA PARK, MD</b>			<b>NOV 15 1982</b>			

BP

10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ROBERT

B.

JACKSON

Jr.

2a. DATE KNOWN OF DEATH  
MONTH DAY YEAR  
11-20-82  
2b. HOUR  
6:40A

3. SEX  
Male

4. RACE  
White

5. DATE OF BIRTH  
MONTH DAY YEAR  
Mar. 27, 1929

6. AGE (IN YEARS)  
LAST BIRTHDAY  
53 YRS.

IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.  
HOURS MIN.

2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
11-20-82  
19

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Maryland

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Anne Arundel County MD.

10. CITY OR TOWN OF DEATH  
Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
North Arundel Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Cook  
12b. KIND OF BUSINESS OR INDUSTRY  
21225

13a. STATE  
Maryland

13b. COUNTY  
A.A.Co.

13c. CITY OR TOWN  
BR. PK.

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
204 Holy Cross Rd. Balto. Md.

14. FATHER'S NAME  
FIRST MIDDLE LAST  
Robert B. Jackson

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Mabel ----- Minton Md. 21230

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
Yes

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
W.W. 2

16c. SOCIAL SECURITY NO.  
228-32-9681

17. INFORMANT ADDRESS  
Mr. William L. Jackson, 829 Light St. Balto.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Blunt trauma to abdomen

DUETO, OR AS A CONSEQUENCE OF

(b)   
DUETO, OR AS A CONSEQUENCE OF

(c)   
DUETO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Chronic alcoholism

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR AM MONTH DAY YEAR  
10:30PM 11-19-82

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
subject fell down basement steps

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
at home

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE  
204 Holy Cross Rd. Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Dennis F. Smyth M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 11-20-82

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE

Nov. 26, 1982

23c. NAME OF CEMETERY OR CREMATORY

Md. Vet. Cem. Crownsville

23d. LOCATION CITY OR TOWN

Crownsville, Maryland

COUNTY STATE

24. FUNERAL DIRECTOR

McMully Funeral Home, 130 E. Fort Ave. Balto. Md.

25a. DATE REC'D. BY REGISTRAR

NOV 24 1982

25b. REGISTRAR'S SIGNATURE

John J. C. Chief

RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

DATE: FEB 10 1964

TO: DIRECTOR, ARS

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 0 4

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P	
ROBERT Everett JACOB, SR.			NOVEMBER 18, 1982			2:15 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH		
Male	White	Oct. 1, 1920	62 YRS.		ANNE ARUNDEL COUNTY MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland	U.S.A.		Carpenter		Construction		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12c. STREET ADDRESS		12d. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		20794/ C55 Holliday Mobile Estates				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland		A.A. Co.	Jessup	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20794/ C55 Holliday Mobile Estates		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Robert Jacob			Caroline Post				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT				
yes		WW II	same as #13 Mrs. Angela N. Jacob-wife-				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Small Cell Lung Ca DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 10, 1982, to Nov 18, 1982, that (I) (we) last saw the deceased alive on Nov 18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE P. Konits				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP H. KONITS, M.D.				22e. ADDRESS 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		22 Nov. 82	Meadowridge Mem Pk		Elkridge, Howard, MD.		
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home		Glen Burnie MD.		NOV 23 1982		John J. Conner	

BP

NOVEMBER 18, 1982 1:15

JACOB, BR.

ROBERT A. 1951

WHITE SPRING COUNTY

NORTH ANGELO HOSPITAL

GLEN EUBANK

U.S. AIR FORCE

UNITED STATES AIR FORCE

NOV 18 1982

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 0 5

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE) <i>Theodore Woolsey Johnson Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-2-82</i>		2b. HOUR <i>5:30 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH (MONTH DAY YEAR) <i>Sept. 26, 1904</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel MD.</i>		
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>11 Acton Place</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Civil Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Engineering</i>
13a. STATE <i>MD.</i>		13b. COUNTY <i>A.A.</i>	13c. CITY OR TOWN <i>ANNAPOLIS</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>11 Acton Place 21409</i>
14. FATHER'S NAME (FIRST MIDDLE) <i>Theodore Woolsey Johnson</i>		15. MOTHER'S MAIDEN NAME (MIDDLE LAST) <i>MARY CRAVEN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>164-07-1050</i>		17. INFORMANT <i>Melita Ames Johnson #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>adrenocarcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>primary site?</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		

## MEDICAL CERTIFICATION

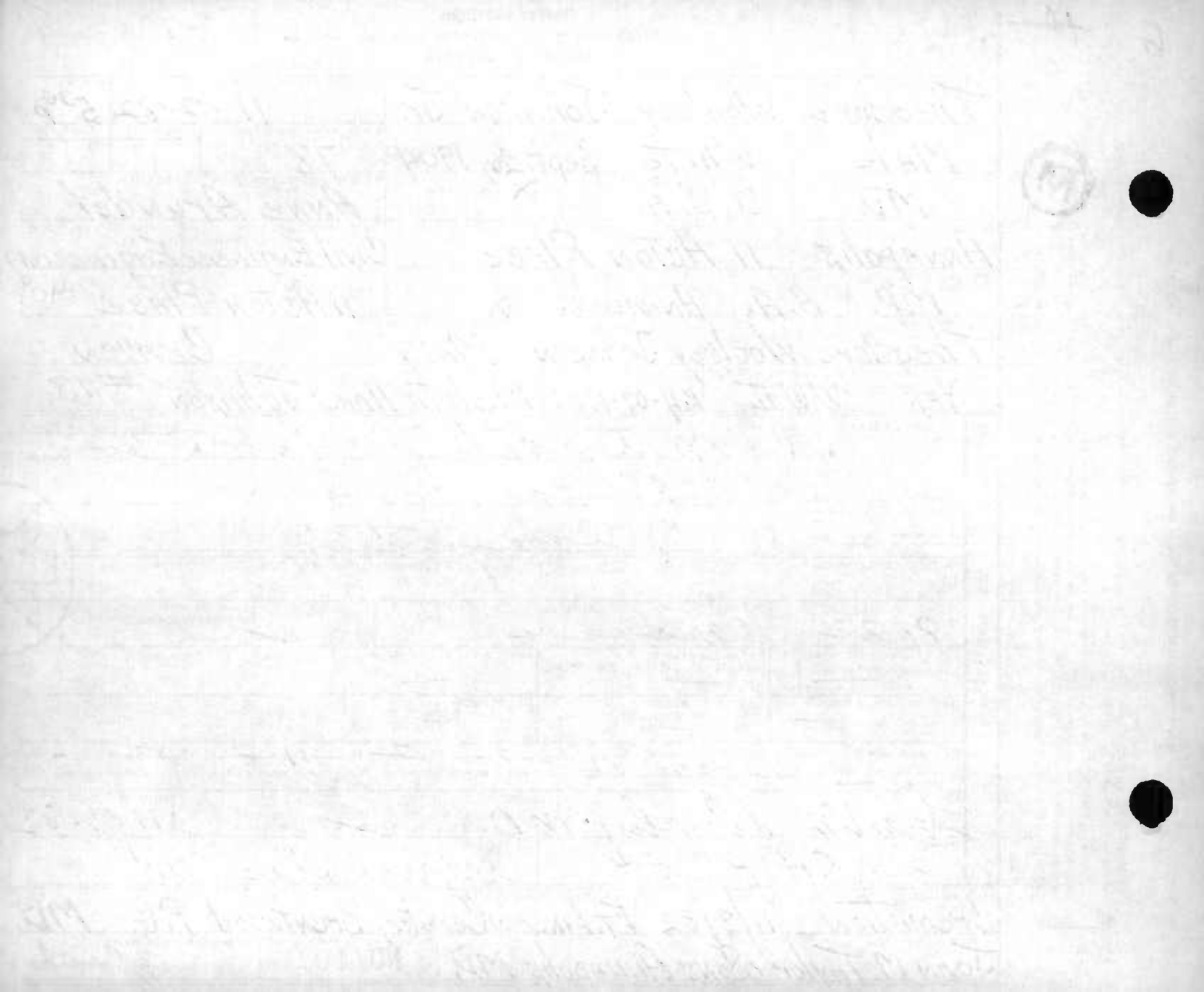
19a. DATE OF OPERATION <i>8/82</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-25, 1982</i> to <i>11-2, 1982</i> , that (I) (we) last saw the deceased alive on <i>10-29-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Frank M. Shipley M.D.</i>		DEGREE <i>M.D.</i>	22c. DATE SIGNED <i>11-3-82</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F.M. SHIPLEY</i>		22e. ADDRESS <i>Annapolis Md</i>	

23a. BURIAL, CREMATION REMOVAL (SPECIFY) <i>CREMATION</i>	23b. DATE <i>11/3/82</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY <i>Brentwood P.G. MD.</i>
24. FUNERAL DIRECTOR (NAME) <i>John M. Taylor &amp; Sons</i>		ADDRESS <i>ANNAPOLIS MD</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 10 1982</i>
		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 0 6 E.S.T.									
1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
FIRST MIDDLE LAST ALICE Virginia JOYCE				MONTH DAY YEAR NOVEMBER 6, 1982				12:35 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH DAY YEAR Oct. 27, 1894		88 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE				NORTH ARUNDEL HOSPITAL				Homemaker				Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Anne Arundel		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7733 Old Annapolis Rd. 21061					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Francis Lankins				FIRST MIDDLE LAST Mary Reis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				220-05-7643 A		Edward L. Joyce, 600 Fennhill Rd. Baltimore Md. 21226							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).													
PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4274 Cardiac Arrest										10 min			
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										2 days			
(b) Hypoxic Brain Damage													
(c) Ventricular Fibrillation										2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, Possible Lung Cancer, Heart Condition in Past													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 1982, to 11/6, 1982, that (I) (we) lost saw the deceased above and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
DAVID A. SCHWARTZ, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4/6/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
				7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				11/9/1982		Holy Cross Cem.		Brooklyn, Anne Arundel Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
McCutty F.H. Mountain & Tick Neck Rds. 21122				Pasadena, Md.				NOV 9 1982 John J. Canich					

BP

RECEIVED  
JAN 10 1964

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 2 2 7 8 0 7	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Stephen Luba</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>11-1-82</b>		2b. HOUR <b>A</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>23</b> YEAR <b>15</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>11-1-82</b>		2d. HOUR <b>A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.					
10. CITY OR TOWN OF DEATH <b>Kenilworth</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Plater - Westinghouse</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS <b>804 Lynvue Road,</b>		21090			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel Co.</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST <b>Mike</b> MIDDLE <b></b> LAST <b>Juba</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Borinych</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>233-07-6631</b>		17. INFORMANT <b>Stephen L. Juba, Sr.</b>		ADDRESS <b>932 E. Patapsco Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) M.D. <b>Depoy</b>				MEDICAL EXAMINER		DATE SIGNED <b>11-1-82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHART</b>				ADDRESS <b>Ann po lis, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet. Cem.</b>				23d. LOCATION CITY OR TOWN <b>Crownsville., A. A. Co., Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Mcully Funeral Homes</b> ADDRESS <b>Balto., Md., 21225</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

COTTON FIBER



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*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Barry Joseph Kahler				2a. DATE OF DEATH November 22, 1982		2b. HOUR 9:45 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH September 19, 1959		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1201 Leonard Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Joanne Kahler				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Joanne Wilmoth, Mother, same as 13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-90-1391		17. INFORMANT ADDRESS Joanne Wilmoth, Mother, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3591 IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DUCHENNE'S MUSCULAR DYSTROPHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>JUNE 19 80</u> , to <u>Nov 19 82</u> , that (I) (we) last saw the deceased alive on <u>Nov 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>Thaddeus Pula</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 23 Nov. 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thaddeus Pula, M. D.				22e. ADDRESS Maryland General Hospital, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24 Nov. 82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Maryland	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE <u>Joan J. Conner</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 0 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
FIRST MARY MIDDLE AMELIA LAST KAPLAN				NOVEMBER 14, 1982			
3. SEX				2b. HOUR			
Female				11:15 AM			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
White		MONTH DAY YEAR		90 YRS.		IF UNDER 24 HRS.	
Sept. 15, 1892		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		MONTHS DAYS		HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Machine Oper.		Md. Box Comp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13b. COUNTY				13e. STREET ADDRESS			
A.A.				20 Birch Ave. 21061			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
George Higdon				Lydia Creighton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT			
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		215-05-6261		ADDRESS			
no				Beatrice M. Stevens same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Circulatory failure</u>							
4140 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>CHF</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>ASHD</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE			
AT WORK AT WORK							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-5-1985</u> to <u>11-14-1982</u> , that (I) (we) last saw the deceased alive on <u>11-1-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
SACIT EREN M.D.				529 S. CAMP MEADE ROAD LINTHICUM, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		17 Nov. 82		Meadowridge Mem. Pk.		Dorsey Howard Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS				NOV 15 1982		John J. Canfield	
James S. Kirkley F.H. Glen Burnie MD.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Margaret E. Kinsley</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 26, 1982</i>		2b. HOUR M <i>M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 26, 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>69</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Glen Burnie, A.A.Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>439 Ingram (t. Glen Burnie, Md.)</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Meat Cutter</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A.Co.</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Luckhardt</i>		16. ADDRESS <i>Henry H. Kinsley, Sr. Same as #13</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-26-1492</i>		17. INFORMANT <i>Henry H. Kinsley, Sr.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4140</i> IMMEDIATE CAUSE (a) <i>Indurated congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HPN + A.I.D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year.</i> <i>years.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>1978</i> , 19____, to _____, 19____, that (we) last saw the deceased alive on <i>Oct 26</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. F. Auer</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/26/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. F. Auer</i>		22e. ADDRESS <i>3001 S. HANOVER ST.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/29/1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, a.a. co., Md.</i>	
24. FUNERAL DIRECTOR <i>McCutty Funeral Home, 237 E. Patapsco Ave., Baltimore, Md. 21225</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 30 1982</i>		25b. REGISTRAR'S SIGNATURE <i>E. F. Auer</i>	

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CONFIDENTIAL

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARIAN Lee KIRWAN			MONTH DAY YEAR NOVEMBER 22, 1982			P M 6:00		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR Jan. 19, 1909	73 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
Maryland	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Civil serv. (ret.)			Balt. City		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			A.A.			Pasadena		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
FIRST MIDDLE LAST Maurice Lee Kirwan			FIRST MIDDLE LAST Molly Northam			-21122-		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no			n/a			-friend- same as # 13		
			212.07.0656			Miss Genevieve Emerine		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE				DEGREE		23b. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/23/82	
23d. PHYSICIAN'S NAME (TYPE OR PRINT)				23e. ADDRESS			
CHARLES J. WU, M.D.				7845 Oakwood Road #204 Glen Burnie, Maryland 21061			

23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation		11-23-82		Security Proc. Inc.		Catonsville, Balt., MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Dean P. Charlton Singleton Funeral Home				NOV 26 1982		John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

15-ES-97-147

STEWART

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 2  
REG. NO. E.S.T.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ESSIE		KITCHEN		NOVEMBER 5, 1982		5:45 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female	Black	X		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S.C.	USA			ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md		AA		Waterburg		13d. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
Major Cawsford		Carrie Radsdale		1305 Sunrise Beach Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				Sallie Freeman 1305 Sunrise Beach Rd.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1990

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
RECEP EROL, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
				325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MARYLAND 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11/9/82	Arbutus Mem. Pk.	Arbutus Balto. Md.
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR
Chas.A.Rice FSPA 1300 Eutaw Pl			NOV: 10 1982
			25b. REGISTRAR'S SIGNATURE
			John J. Conish

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Dayton T Lamont</i>			2a. DATE OF DEATH MONTH <i>11</i> / DAY <i>7</i> / YEAR <i>82</i>		2b. HOUR <i>1:00 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>5</i> - DAY <i>13</i> - YEAR <i>1900</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisc.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.		
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Arundel Convalescent Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Librarian</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Florida</i>	13b. COUNTY	13c. CITY OR TOWN <i>Cocoa</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>1304 North Fisk Blvd.</i>	
14. FATHER'S NAME FIRST <i>Hugh</i> MIDDLE LAST <i>Lamont</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Myrtle</i> MIDDLE LAST <i>Brereton</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>266-56-1015</i>	17. INFORMANT <i>Davidsonville, Maryland</i> <i>Thair Lamont, 3733 Patuxent Manor Rd.</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4360 IMMEDIATE CAUSE (a) CVA → Respiratory arrest</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Sec. D &amp; C H.F.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <i>19 80</i> to <i>10 28</i> , 19 <i>82</i> , that (we) lost saw the deceased alive on <i>10 28</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mustafa C Ozturk MD</i>				22c. DATE SIGNED <i>11-7-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mustafa C Ozturk</i>				22e. ADDRESS <i>605 Bx A Blvd Severna park</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/10/82</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Pleasant Cem.</i>		23d. LOCATION CITY OR TOWN <i>Lodi, Wisconsin</i> COUNTY <i>Mad.</i> STATE <i>Wis.</i>
24. FUNERAL DIRECTOR <i>Beall Funeral Home</i> <i>16000 Annapolis Rd., Bowie, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 10 1982</i>		

no ..... 300-6-10121

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 4

1. FOR STATE REGISTRAR		REG. NO.		E.S.T.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY MIDDLE M LAST LAY		2a. DATE OF DEATH MONTH DAY YEAR	
				NOVEMBER 22, 1982	
3. SEX Female		4. RACE White		2b. HOUR 8:06 A	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10' 6' 27		55 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Virginia		U.S.A.		ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		housewife	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Md.		A.A.		115 Glenlea Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Robert Scott		Bessie Walton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-24-0664		George G. Lay 115 Glenlea Dr. 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recent CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HSCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/5/82</u> to <u>11/22/82</u> , that (I) (we) last saw the deceased alive on <u>11/22/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>David A. Schwartz</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>11/22/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DAVID A. SCHWARTZ, D.O.		7845 OAKWOOD ROAD, #200 GLEN BURNIE, MARYLAND, 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		10/24/82		Crest Lawn Cem.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Gonce F.H.		NOV 23 1982		<u>John J. Carver</u>	
4001 Ritchie Hwy. 21225					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 855-5435.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 5

1. FOR STATE REGISTRAR **Palmer Q. Leasher**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Palmer Q Leasher</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>82</b>		2b. HOUR <b>9:00 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>8</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE COUNTRY <b>A, USA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Pasadena</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>210 Lake Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Burner Beth Steel</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Ind. A.A.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Riviera Bch.</b>
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary Jane</b> MIDDLE <b>Workman</b> LAST <b>Workman</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>211-05-9280</b>		17. INFORMANT ADDRESS <b>Geraldine Leasher (same as 13c)</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

**1629**

IMMEDIATE CAUSE (a) **Metastatic CANCER OF Lung**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**3 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>July</b> , 19 <b>82</b> , to <b>Oct</b> , 19 <b>82</b> ; that (2) (we) last saw the deceased alive on <b>10/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>David A. Schwartz</b>		22c. DATE SIGNED <b>4/1/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID A. SCHWARTZ</b>		22e. ADDRESS <b>7845 Oakwood Rd, 65, Ind 21061</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/4/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Md.</b>
24. FUNERAL DIRECTOR NAME <b>Balto., Md. 21225</b> <b>George J. Gonce F.H. 4001 Ritchie Hgwy.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1982</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-54-3520.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 1 6 REG. NO.		EST	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) ANNA LEE PIERCE LEE				NOVEMBER 13, 1982		6:35 P <sub>M</sub>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 1, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX				13e. STREET ADDRESS 132 Carrol Road 21061			
14. FATHER'S NAME Joseph S. Helms				15. MOTHER'S MAIDEN NAME Frances L. Arrowood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-12-0882		17. INFORMANT (Brother) ADDRESS Mr. Harold J. Helms Baltimore, Md. 21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CUA</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHF - Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased on <u>11/13/82</u> , to <u>11/13/82</u> , that (I) (we) lost the deceased on <u>11/13/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>George B. Ramirez</u>		22c. DEGREE ATTENDING PHYSICIAN		22d. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>11/14/82</u>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE B. RAMIREZ, M.D.		22g. ADDRESS 7845 OAKWOOD ROAD #205 GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Md.	
24. FUNERAL DIRECTOR NAME <u>B. N. Hopkins</u>		24b. ADDRESS Singleton Funeral Home, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR <u>11-16-82</u>		25b. REGISTRAR'S SIGNATURE	

BP

White House



11/10

November 10

CHS - Bureau of Land Management

11/10/11

11/10/11

11/10/11

11/10/11

11/10/11

11/10/11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Wilma L. Lee</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>82</b> 2b. HOUR <b>9:10 AM</b>		
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>9</b> YEAR <b>04</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.		
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>Pa.</b>	13b. COUNTY <b>BEAVER</b>	13c. CITY OR TOWN <b>Vanport</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Cyril</b> MIDDLE <b>RENNER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MEARIMAN</b> MIDDLE <b>15009</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT <b>HARRY A. LEE</b>	
16c. (IF YES, GIVE WAR OR DATES)		17a. ADDRESS <b>303 BEACH</b>		17b. CITY OR TOWN <b>ANNAPOLIS</b>	
16d. (IF YES, GIVE WAR OR DATES)		17c. STATE <b>MD.</b>		17d. ZIP CODE <b>21403</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4110

IMMEDIATE CAUSE (a) **Auto road failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Dissection abdominal aorta**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Atherosclerotic cardiovascular disease**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Accelerated hypertension**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> , 19 <b>82</b> , to <b>11-20</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11-20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>G. A. Mitchell MD</b>				22c. DATE SIGNED <b>11-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. A. Mitchell MD</b>				22e. ADDRESS <b>205 R. 2006 ANNAPOLIS MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11/24/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CEM</b>	23d. LOCATION CITY OR TOWN <b>BEAVER</b> COUNTY <b>BEAVER</b> STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b>		24b. ADDRESS <b>ANNAPOLIS MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

110

2000 COLL

CHIEFLIN



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 7 8 1 8  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret THOM Leith

3. SEX FEMALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 1 3 1899 6. AGE (IN YEARS LAST BIRTHDAY) 83 7b. DATE OF DEATH MONTH DAY YEAR 11 23 82 7c. HOUR 5:43 PM

7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND 7e. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD

10. CITY OR TOWN OF DEATH ANNAPOLIS 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) A.H. GEN Hospt 12a. USUAL OCCUPATION (IF DECEASED FOR MOST OF WORKING LIFE) BOOKKEEPER 12b. KIND OF BUSINESS OR INDUSTRY BANKING

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE CITY OR TOWN MD. BA Co ANNAPOLIS 13c. INSIDE CITY LIMITS? YES ☐ NO ☒ 13d. STREET ADDRESS 1264 HILLSHORE DR 21403

14. FATHER'S NAME FIRST MIDDLE LAST THOM 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO 17. INFORMANT ADDRESS STEWART M. LEITH #3

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
4029 IMMEDIATE CAUSE (a) Cardiac Arrest.  
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/23 1972 to 11/23 1982, and that (I) (we) last saw the deceased alive on 11/17 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED 11/24/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD PEELE 22e. ADDRESS 121 Cathedral St. Annapolis MD.

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) CREMATION 23b. DATE 11/24/82 23c. NAME OF CEMETERY OR CREMATORY F.H. Church 23d. LOCATION CITY OR TOWN COUNTY STATE BETHESDA P.G. MD.

24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ADDRESS ANNAPOLIS MD 25a. DATE REC'D. BY REGISTRAR NOV 30 1982 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>AWA M. Lighter</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 82</b>			2b. HOUR <b>10<sup>30</sup> P. M.</b>					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 21 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
12. CITY OR TOWN OF DEATH <b>CROFTON</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Convalescent Center</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b> 16b. COUNTY <b>Prince George's</b> 16c. CITY OR TOWN <b>Bowie</b>			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS <b>12810 Buckingham Dr.</b>					
19. FATHER'S NAME FIRST MIDDLE LAST <b>John Shank</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ester Downey</b>								
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			22. SOCIAL SECURITY NO. <b>219-54-1589</b>			23. INFORMANT <b>LAURA L. Hunt</b>			24. ADDRESS <b>Bowie, MD</b>		
25. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1539 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest</b>									26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed</b>		
DUE TO, OR AS A CONSEQUENCE OF: (b) <b>metastatic cancer colon</b>									27. <b>1 yr.</b>		
DUE TO, OR AS A CONSEQUENCE OF: (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
28. DATE OF OPERATION			29. CONDITION FOR WHICH OPERATION WAS PERFORMED			30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			37. LOCATION STREET CITY OR TOWN COUNTY STATE					
38. I certify that (a) this hospital attended the deceased from <b>OCT 6 19 82</b> , to <b>NOV 30 19 82</b> , that (b) (we) last saw the deceased alive on <b>NOV 30 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.											
39. SIGNATURE <b>H. L. Muncie, Jr.</b>			40. DEGREE <b>MD</b>			41. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			42. DATE SIGNED <b>12/1/82</b>		
43. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. L. Muncie, Jr.</b>			44. ADDRESS <b>326 Lynwood Dr. Severna Park, Md.</b>								
45. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			46. DATE <b>12-3-82</b>		47. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>			48. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>			
49. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b>						50. ADDRESS <b>Boonsboro, Md. 21713</b>		51. DATE REC'D. BY REGISTRAR <b>DEC 6 - 1982</b>		52. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR Home 11/16/82 rc 1. STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Kate Annette Lindquist</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 13, 1982</b>			2b. HOUR <b>1 P</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 14, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Red U.S.N.A. Civil Service</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>					13b. CITY OR TOWN <b>Annapolis</b>		13c. STREET ADDRESS <b>225-B Farragut Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Friedrich Wilhelm Kahlenkamp</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annette Helene Lindenberg</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>093-149199</b>		17. INFORMANT <b>Lindquist</b>			ADDRESS <b>Same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2028 lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19____ to <b>11/14/82</b> , 19____, that (I) <del>was</del> last saw the deceased alive on <b>11/14/82</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> (did) view the body after death.									
22b. SIGNATURE <b>Michael L. Watkins</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SO WATKINS</b>				22e. ADDRESS <b>121 Cathedral St, Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 17, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ferncliff</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hartsdale Westchester NY</b>			
24. FUNERAL DIRECTOR NAME <b>John M Taylor &amp; Sons, Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			



Female  
Germany  
Hansel's from Handel's  
George Handel's  
No. 1



Handel's  
No. 1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 2 1

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helen Evelyn Lloyno			2a. DATE OF DEATH MONTH DAY YEAR 11 16 82			2b. HOUR 10 <sup>30</sup> AM		
3. SEX Female		4. RACE CA		5. DATE OF BIRTH MONTH DAY YEAR 7 14 01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) HALL STATION, MD		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor nursing home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY A. A.		13c. CITY OR TOWN Gambrells		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Leonard Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Josephine Super			16. STREET ADDRESS 932 Waugh Charles Rd.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) - NO -			16b. SOCIAL SECURITY NO. 220-24-7855		17. INFORMANT Phyllis J. Milewski 932 Waugh Charles Rd. Gambrells, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). INTRA-ABDOMINAL INFECTION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (in this hospital) attended the deceased from Nov 1, 1982, to Nov 16, 1982, that (we) last saw the deceased alive on Nov 11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Barry R. Nathanson MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/16/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 1438 DEFENSE HWY. GAMBRELLS, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-19-82		23c. NAME OF CEMETERY OR CREMATORY St Stephens		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				ADDRESS 12 Ridgeside Ave. Annapolis, Md.		DATE REC'D. BY REGISTRAR NOV 18 1982		25. REGISTRAR'S SIGNATURE John J. Grier

MEDICAL CERTIFICATION

9 9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 2 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JENNIE MAE LONG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-29-82</b>			2b. HOUR <b>7:02 A.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 29, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>906 Primrose Rd., Apt. 303</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Issac M. Cooper</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mittie Herndon</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>no</b>			16b. SOCIAL SECURITY NO. <b>242-36-9292</b>		17. INFORMANT ADDRESS <b>Mary Steadman, 906 Primrose Rd., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Obstructive Pulmonary Disease</b> <b>4920</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Chronic YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEVERE OSTEOPOROSIS</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/29 1982</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29 1982</b> to <b>11/29 1982</b> , that (I) (we) last saw the deceased alive on <b>11/29 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>David Krims MD</b> DEGREE <b>MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/29/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Krims</b>						22e. ADDRESS <b>25 Shaw St., Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shepherd's Memo. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hendersonville, N.Ca.</b>			
24. FUNERAL DIRECTOR <b>Beall Funeral Home</b> NAME ADDRESS <b>16000 Annapolis Rd., Bowie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>				

MEDICAL CERTIFICATION



16000 Annolis Pt., Bowie, Md.  
Beall Funeral Home  
12/25/52  
Special Home Bk. Hendersonville, N.C.  
22 Shaw St., Annolis, Md.  
E. vic. Krimins  
no. 242-36-0222 Mary Stearns, 305 Primrose, W.  
Iss. C. M. Cooper Middle Annolis 305 Primrose, W.  
Mr. A.A. Annolis 305 Primrose, W.  
Annolis Anne Arundel General Hospital, Hospital Home  
North Carolina, U.S.A.  
Form 10 C-101 May 29, 1952  
11-44-52

16000 Annolis Pt., Bowie, Md.  
Beall Funeral Home  
12/25/52  
Special Home Bk. Hendersonville, N.C.  
22 Shaw St., Annolis, Md.  
E. vic. Krimins  
no. 242-36-0222 Mary Stearns, 305 Primrose, W.  
Iss. C. M. Cooper Middle Annolis 305 Primrose, W.  
Mr. A.A. Annolis 305 Primrose, W.  
Annolis Anne Arundel General Hospital, Hospital Home  
North Carolina, U.S.A.  
Form 10 C-101 May 29, 1952  
11-44-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 2 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Donald Joseph Lord SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 82</b>		2b. HOUR <b>4 00 PM</b>	
3. SEX <b>male</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 22 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>anne arundel general</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>Anne arundel</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>135 GROVE LANE 21403</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph F. Lord</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna McCarthy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>511'30'8084</b>		17. INFORMANT <b>Dora Elia Lord</b>		ADDRESS <b>Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>4960</b> IMMEDIATE CAUSE (a) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 08</b> , 19 <b>82</b> , to <b>SEPT. 17</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles W. Kinzer</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov 26, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles W Kinzer</b>				22e. ADDRESS <b>Annapolis, MD 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 29, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Switzland P.G. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis MD</b>				25a. DATE RECD. BY REG. CLERK <b>NOV 30 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cairish</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 2 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LOST CHARLES Louis LOSTIMOLO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 15, 1982</b>			2b. HOUR <b>10<sup>21</sup> P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 7 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cobbler</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Salem Shoe Repair</b>	
13a. STATE <b>Mass</b>			13b. COUNTY <b>Essex</b>	13c. CITY OR TOWN <b>Lawrence</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip Lostimolo</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rozzia Cali</b>			13e. STREET ADDRESS <b>163 Union St. Mass. 01840</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1943-1946 001'16'1303</b>		17. INFORMANT ADDRESS <b>Rocco Lostimolo 2 Crest Drive Methuen, Mass 01844</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Acute inferior myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arterio-sclerotic end stage renal disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>11-15</b> , 19 <b>82</b> , to <b>11-15</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>11-15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <b>G. Mitchell</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-15-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GA Mitchell MD</b>				22e. ADDRESS <b>205 Ridge Ave Annapolis</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 19, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bellevue</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lawrence Essex Mass.</b>	
24. FUNERAL DIRECTOR NAME <b>John M Taylor &amp; Sons - Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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CHARLES LOUIS ROSS

Nov 15 1920

Male White 1 7 23 22

Mr. Charles Ross X Anne Ross

Mr. Charles Ross X Anne Ross

Mr. Charles Ross X Anne Ross

Mr. Charles Ross X Anne Ross

Mr. Charles Ross X Anne Ross

CHIEF

100% COTTON

Nov 15 1920

Nov 15 1920



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ralph Lloyd Lowman</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>5</b> YEAR <b>82</b>			2b. HOUR <b>2:37 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>27</b> YEAR <b>1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b>		8. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A. GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REAL ESTATE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>REALTY</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>RALPH</b> MIDDLE <b>L.</b> LAST <b>LOWMAN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>LUCY</b> MIDDLE <b>STANKIEWICZ</b> LAST <b>STANKIEWICZ</b>			16. STREET ADDRESS <b>1201 STERLING DR 21403</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>Yes 1953-1955</b>			16b. SOCIAL SECURITY NO. <b>1953-1955 213-28-5914</b>			17. INFORMANT <b>Dolores D. Lowman</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Same as #13</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 5, 1982</b> to <b>NOVEMBER 5, 1982</b> , that (I) (we) last saw the deceased alive on <b>Nov. 5</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. Caputo</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. CAPUTO</b>						22e. ADDRESS <b>25 Shaw Street, Annapolis, MD 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (IF ANY) <b>Burial</b>			23b. DATE <b>Nov. 8, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>		
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons - Annapolis, MD</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 10 1982 John J. Gault</b>			

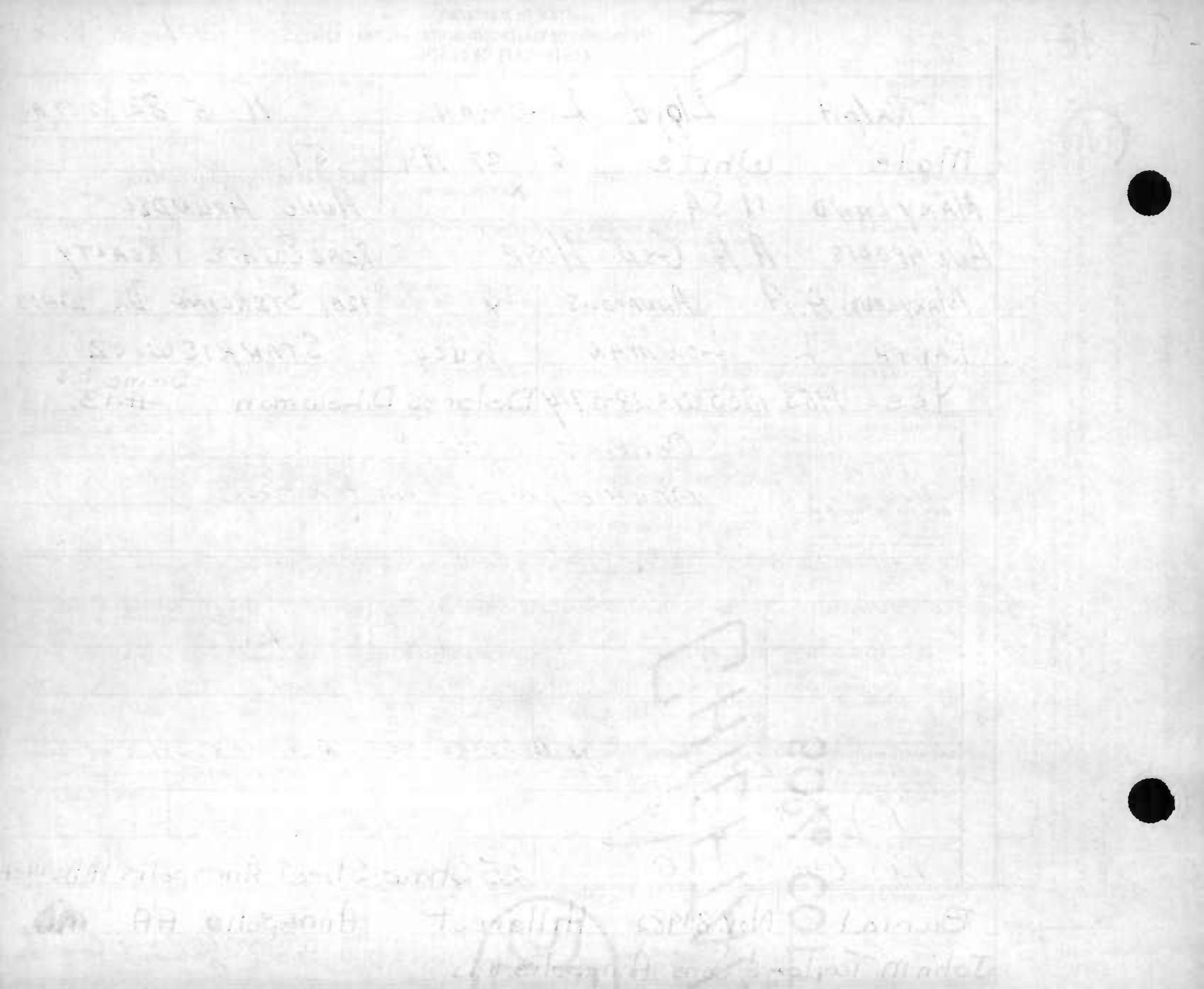
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 2 7 8 2 6

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE Winiferd MADDOX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 4, 1982</b>		2b. HOUR P M <b>4:20 P M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>70 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Analyst (RET)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NSA</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co</b>		13c. CITY OR TOWN <b>GlenBurnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>Glenlaa Drive</b>		13f. CITY OR TOWN <b>21061</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Boyd Lawrence Maddox</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arie Carwile</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT P.O. Box 665 Amherst, VA 24521 <b>Mr. David Driskill (Cousin-D/D)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral infarction</b> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Sepsis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/3/82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE <b>11/4/82</b>	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/3/82</b> to <b>11/4/82</b> , that (I) (we) last saw the deceased alive on <b>11/3/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.	
22b. SIGNATURE <b>Jorge B. Ramirez</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/4/82</b>		22d. ADDRESS <b>7845 Oakwood Road #205 Glen Burnie, Maryland 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7 NOV '82</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Zion United - Meth. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rustburg Camel Co. VA</b>	
24. FUNERAL DIRECTOR NAME <b>J. Easter</b>		ADDRESS <b>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 2 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

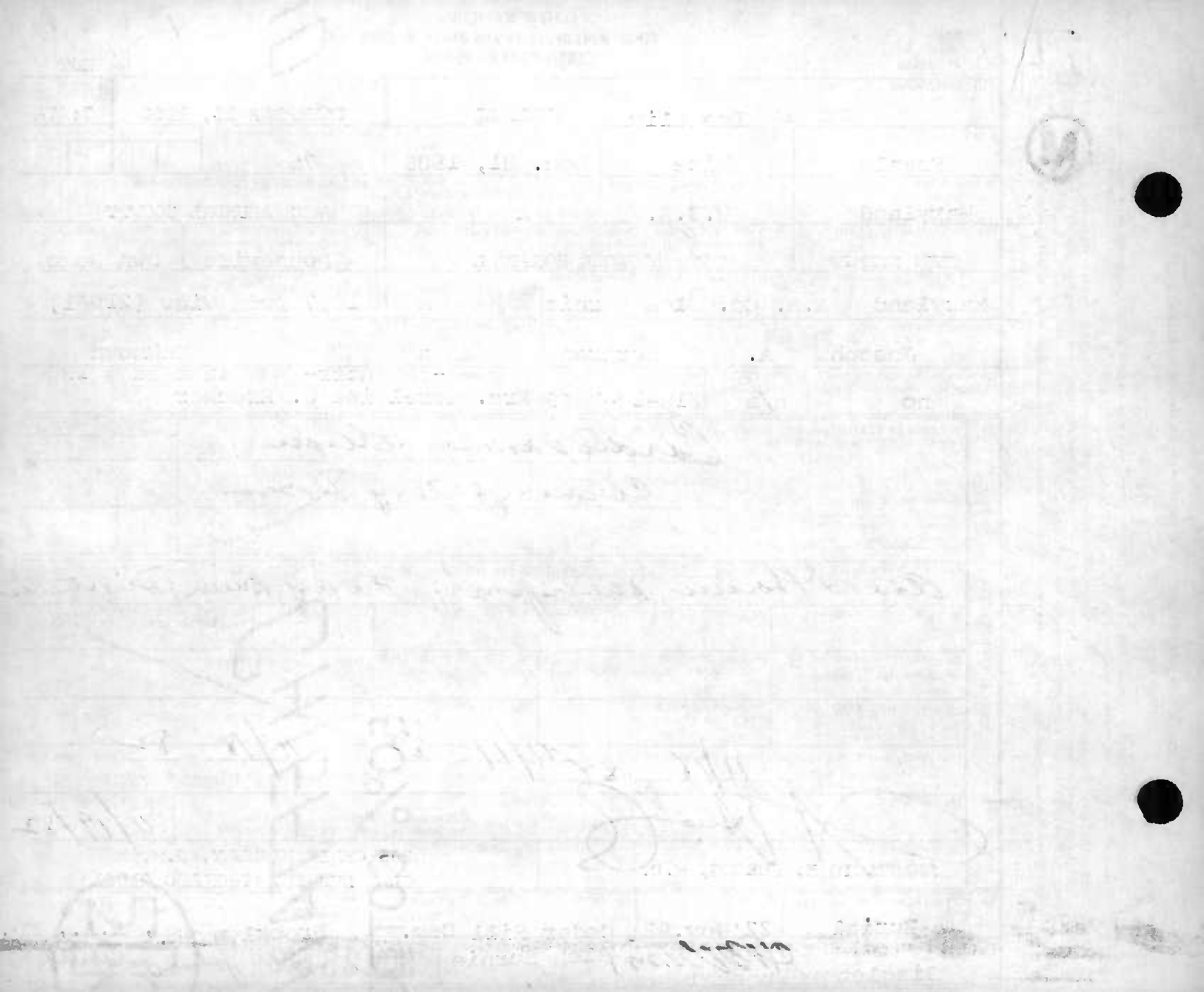
EST

1. DECEASED NAME (TYPE OR PRINT) CECELIA Lee Olivia MARSHALL			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1982			2b. HOUR 7:47AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
						12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		
			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1007 Twin View (21061)		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Norgran				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT - daughter - ADDRESS same as # 13 Mrs. Geraldine O. Krecher			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Acc. &amp; Pharyngeal Surgery; Fr. leg. Arm; Dehydration</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STR. T. FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>82</i> to <i>11/18</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>11/18</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Anastacio E. Subong</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/19/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTACIO E. SUBONG, M.D.		22e. ADDRESS 205 CRAIN HIGHWAY, S.W. GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 Nov. 82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A., MD.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home MD.		25a. DATE REC'D. BY REGISTRAR <i>11/23/82</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 3 2 8  
E.S.T.

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES HOWARD MAUK			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 19, 1982			2b. HOUR A. M. 12:02			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Blair Co., PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRR		12b. KIND OF BUSINESS OR INDUSTRY Retired.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1000 Nabbs Creek Road 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Howard R. Mauk				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora McGreagor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Ruth Mauk, Sister, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio pulmonary arrest</i> 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>year</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <i>stroke before accident</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 3</i> , 19 <i>82</i> , to <i>Nov 18</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Nov 18</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. E. KAPLAN</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/19/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. E. KAPLAN</i>			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 Nov 82		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Altoona Blair PA			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				ADDRESS		25. DATE REC'D. BY REGISTRAR NOV 19 1982		25. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>	

BP

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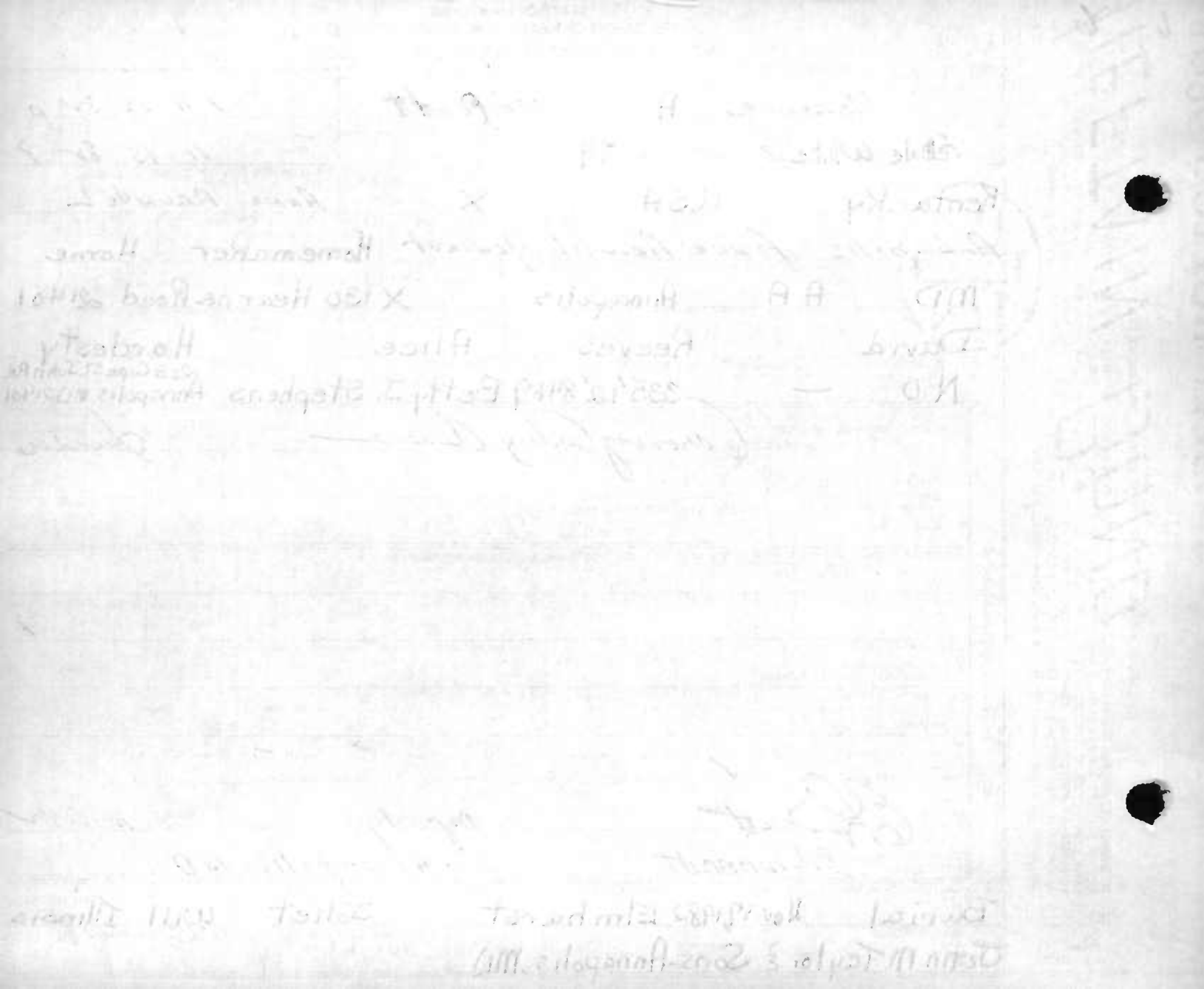
CHIEF

RECEIVED  
JAN 1 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 27829		
1. DECEASED NAME (TYPE OR PRINT) <b>Florence A Meifert</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> 11 15 1982		2b. HOUR <b>9</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>10</b> YEAR <b>03</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>19</b> YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD <b>11 15 1982</b>		2d. HOUR <b>9</b> M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.						
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>130 Hearne Road 21401</b>				
14. FATHER'S NAME FIRST <b>David</b> MIDDLE _____ LAST <b>Reeves</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE _____ LAST <b>Hardesty</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>335'12'8469</b>		17. INFORMANT <b>Betty J. Stephens</b>		ADDRESS <b>203 Cape St. John Ad Annapolis, MD 21401</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Artery Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>11-15-82</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>				ADDRESS <b>Annapolis - MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 19, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmhurst</b>		23d. LOCATION CITY OR TOWN <b>Joliet</b> COUNTY <b>Will</b> STATE <b>Illinois</b>				
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons - Annapolis, MD</b> ADDRESS						25a. DATE REC'D BY REGISTRAR <b>NOV 17 1982</b>		25b. REGISTRAR SIGNATURE <b>[Signature]</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

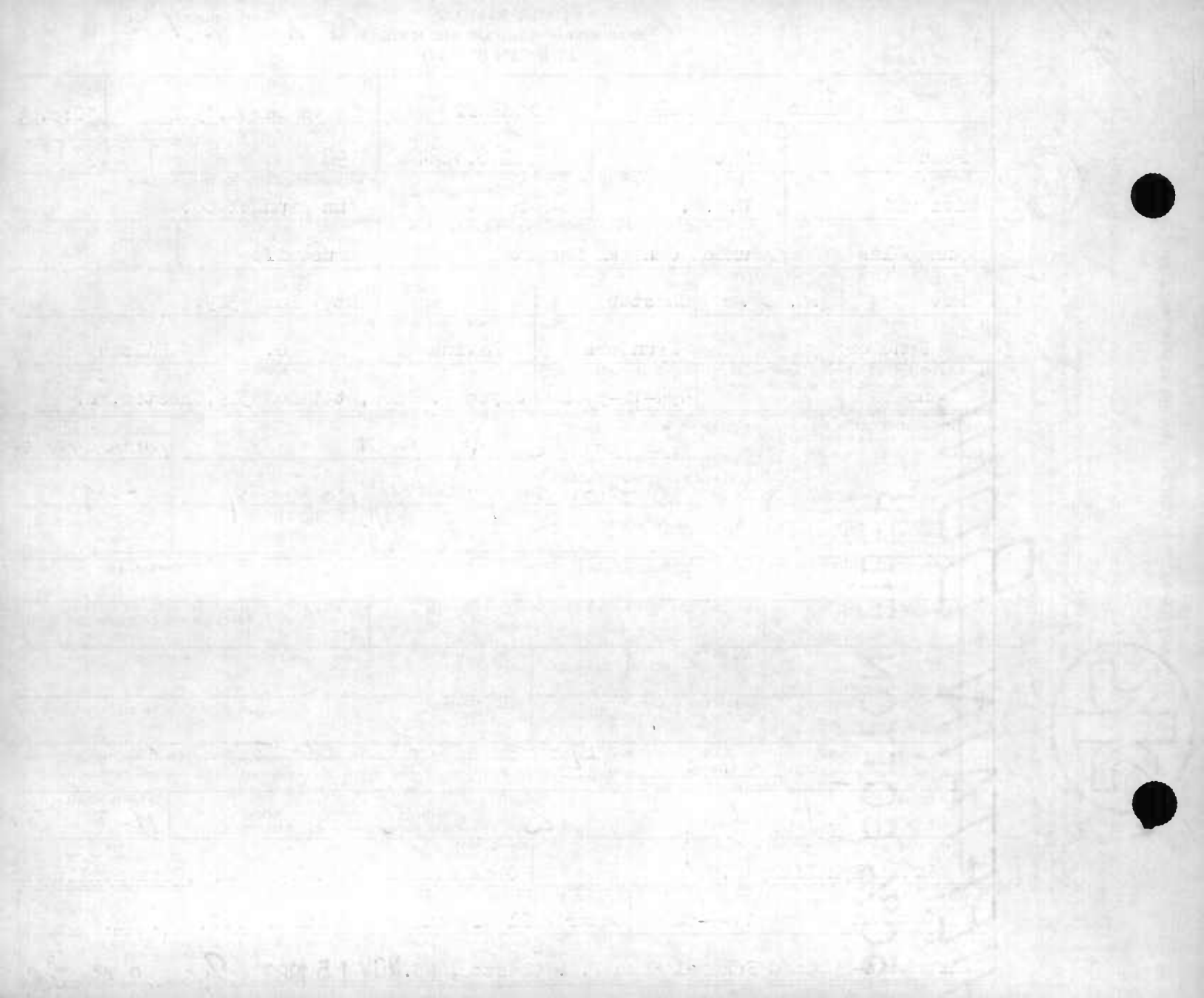
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 2 7 8 3 0				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Willo Bell Midkiff					November 8, 1982				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		April 8, 1884		98		10: a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Missouri		U.S.A.				Ann Arundel Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Arundel General Hospital				housewife			
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Md.					Q.A. Co. Chester		Rt#1 Box #329		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Fancher					Saunders				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no					494-12-5002		Joyce P. Snow, Rt#1 Box#329, Chester, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									IMMEDIATE
4110									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									2 yr.
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>68</u> , to <u>11-8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE						22c. DATE SIGNED	
<u>[Signature]</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						11-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Dr. Ralph Libby M.D.				Grasonville Medical Center, Grasonville Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		11-9-82		Cedar Hill Crematory		SUITLAND P.G. CO. Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Helfenbein-Hubbard Funeral Home P.A. Chester, Md.				NOV 15 1982		<u>[Signature]</u>			

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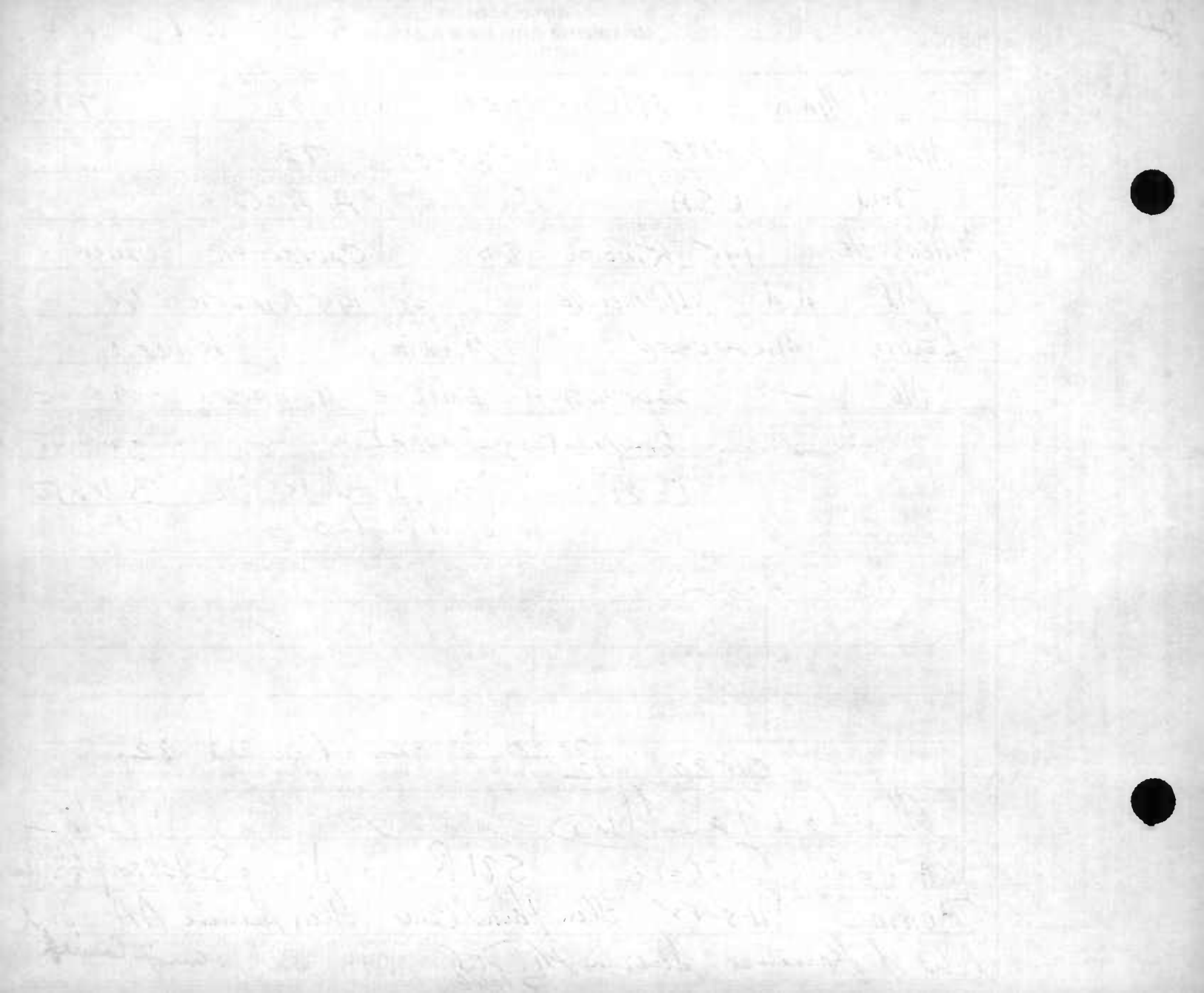
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 7 8 3 1							
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH		2b. HOUR					
FIRST MIDDLE LAST										MONTH DAY YEAR		HOUR MIN.					
WILLIAM E. MILHAUSEN										11/2/82		7:15A					
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			WHITE			MONTH DAY YEAR 10-25-09			73			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Md			USA						A-A-C								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Millersville			195 KINDER RD							CARPENTER			UNION				
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md										AA		Millersville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		195 KINDER RD	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST					FIRST MIDDLE LAST												
LEWIS MILHAUSEN					MINNIE KINDER												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT ADDRESS							
NO					220032514					EMILIE MILHAUSEN - ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a):										3 minutes							
1850 DUE TO, OR AS A CONSEQUENCE OF																	
(b):										3 years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(c):																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
None known																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Oct 30 19 82 to Nov 2nd 19 82, that (I) (we) last saw the deceased alive on Oct 30 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED							
22b. SIGNATURE										11/2/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
KATHERINE FARRELL										581 Richard Way SEVERNA Pk Md 21146							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			11-5-82			Glen Haven Cem			Glen Haven AA Md								
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John J. Bananco										NOV 8 1982				John J. Bananco			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 2 7 8 3 2		REG. NO.		D.S.T.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
REITA A. MOORE				NOVEMBER 25, 1982								10:04AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		White		Dec. 3 1891		90		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				ANNE ARUNDEL COUNTY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Glen Burnie		NORTH ARUNDEL HOSPITAL		Seamstress		Wards									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		A.A.		Linthicum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		526 Forestview Rd. (21090							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
John		Phillips		Olevia											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		220-22-8796		Gladys Tyler (same as 13e)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>										Immed					
4100 DUE TO, OR AS A CONSEQUENCE OF															
(b) <u>myocardial infarct</u>										Few days					
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>coronary art. disease</u>										years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK								STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 23</u> , 19 <u>82</u> , to <u>Nov 25</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Nov 24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>Ira E. Kaplan</u> MD										11/25/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
IRA E. KAPLAN, M.D.				7845 OAKWOOD ROAD, SUITE 200											
				GLEN BURNIE, MARYLAND 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				11/27/82		Dorchester Mem. Pk.				Cambridge Md.					
24. FUNERAL DIRECTOR'S NAME				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
George J. Gonce F.H. 4001 Ritchie Hwy.				NOV 26 1982				<u>John J. Gonce</u>							

0.8.7.

NOVEMBER 23, 1965 10:0 AM

MOORE

DELTA

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NOV 23 1965

11:00

Female

WHITE AGRICULTURAL COUNTY

U.S.A.

Married

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NORTH AGRICULTURAL HOSPITAL

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1111-1111-1111 Tyler (same as 1111)

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7425 CANNON ROAD, SUITE 200  
PLA EUREKA, EUREKA 94501

1111 E. KAPLAN, M.D.

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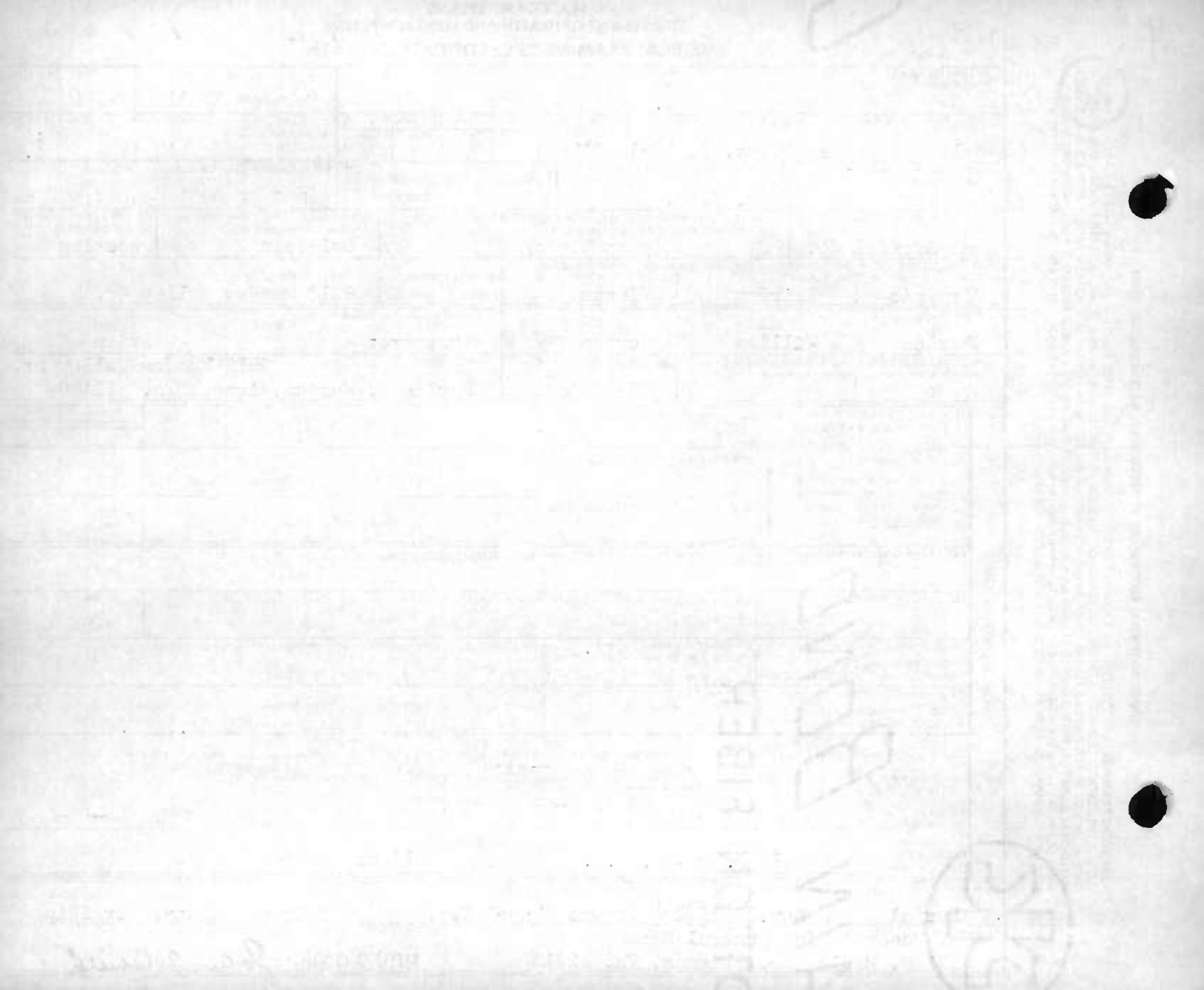
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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																																					
1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH										2b. HOUR																																																																															
Robert J. Morgan										MONTH DAY YEAR										2b. HOUR																																																																															
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.										9. DATE PRONOUNCED DEAD										10. HOUR																													
Male										White										Sept. 9, 1951										31 YRS.										MONTHS										DAYS										HOURS										MIN.										11. MONTH DAY YEAR										12. HOUR									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										10. HOUR																																																											
New York										U. S. A.										WIDOWED										Anne Arundel County,										4:50 P. M.																																																											
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION										12b. KIND OF BUSINESS OR INDUSTRY										13. HOUR																																																											
Anne Arundel Co.										Severn River										Salesman										Boating										13. HOUR																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. STREET ADDRESS										14. HOUR																																																											
Virginia										Fairfax										Vienna										9812 Meadow Valley Dr.										14. HOUR																																																											
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. DATE DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										18. HOUR																																																	
Charles William Morgan										Margaret O'Brian										No										263-92-1592										Charles E. Morgan, Vienna, Va.										22180																																																	
18. CAUSE OF DEATH										19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																											
PART I DEATH WAS CAUSED BY:										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
9109 IMMEDIATE CAUSE (a)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Drowning										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
DUE TO, OR AS A CONSEQUENCE OF										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
(b)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
DUE TO, OR AS A CONSEQUENCE OF										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
(c)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
19a. DATE OF OPERATION										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
XX										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
21d. INJURY OCCURRED WHILE AT WORK										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
XX										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Water										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
21f. LOCATION (CITY OR TOWN, COUNTY, STATE)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Severn River, Anne Arundel Co., Md.										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
22a. I certify that I took charge of the remains described above, held on death resulted from										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Natural causes										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Accident										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Suicide										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Homicide										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Undetermined manner										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
22b. I certify that I took charge of the remains described above, held on death resulted from										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Natural causes										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
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Homicide										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Undetermined manner										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
23a. ACTUAL SIGNATURE										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Dennis F. Smyth, M.D.										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
23b. EXAMINER'S NAME (TYPE OR PRINT)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Dennis F. Smyth, M.D.										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
23c. ADDRESS										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
111 Penn Street										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
23d. LOCATION (CITY OR TOWN, COUNTY, STATE)										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Fairfax County, Virginia										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
24. FUNERAL DIRECTOR NAME										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
Money & King Funeral Home										20. DATE OF OPERATION										21. CONDITION FOR WHICH OPERATION WAS PERFORMED?										22. AUTOPSY?																																																																					
171 W. Maple Ave., Vienna, Va.										20. DATE OF OPERATION										21. CONDITION FOR WHICH																																																																															





FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LAURA BETH NORDQUIST</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>12</b> YEAR <b>82</b>			2b. HOUR <b>11:30 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>15</b> YEAR <b>66</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>16</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co</b> MD.	
10. CITY OR TOWN OF DEATH <b>SEVERNA PK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>567 HIGH BANK RD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HIGH School</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>SEVERNA PK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>DEAN</b> MIDDLE <b>O.</b> LAST <b>NORDQUIST</b>		15. MOTHER'S MAIDEN NAME FIRST <b>NANCY</b> MIDDLE <b>A</b> LAST <b>AMANN</b>		16. SOCIAL SECURITY NO.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>DEAN O. NORDQUIST - ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute leukemia</b> <b>2080</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>82</b> , to <b>11/12</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/9</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Lorraine M. Dailey M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/13/82</b>	
22d. LORRAINE M. DAILEY		22e. ADDRESS <b>8667 FT SMALLWOOD RD PASADENA MD</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>CREMATION</b>		23b. DATE <b>11-15-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW</b>		23d. LOCATION CITY OR TOWN COUNTY <b>WESTVIEW BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>Andres S. Baranco</b> ADDRESS <b>Severna Pk 2nd</b>		25a. DATE OF REGISTRATION <b>NOV 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

CHILKIN, JIM

22 OCTOBER 1957

Dear Jim,  
I have just received your letter of the 10th and am  
glad to hear from you. I am well and hope this  
letter finds you the same. I am still in the  
hospital and am not sure when I will be able to  
write you again. I am sure that you are all  
well and hope to see you soon.  
With love,  
John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 3 5  
EST  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		AUGUSTINE PALMER		MONTH DAY YEAR		8:56A <sub>M</sub>	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY WATKINS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT SARAH FARMER HORNE		ADDRESS Pasadena, Md. 309 Pineview Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, HTN, DM 4/00 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute inf. MI (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/7/82 to 10/7/82, that (I) (we) lost saw the deceased alive on 10/7/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. T. Towhidian, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID A. TOWHIDIAN, M.D.		22e. ADDRESS 3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-16-1982	
23c. NAME OF CEMETERY OR CREMATORY ASBURYTOWNECK CEME..		23d. LOCATION CITY OR TOWN COUNTY STATE Severna Pk. A.A. Maryland		24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR NOV 16 1982	
25b. REGISTRAR'S SIGNATURE John J. Carver							

CLASS CURVE

UNITED STATES GOVERNMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 3 6

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold W. Parker		2a. DATE OF DEATH MONTH DAY YEAR November 22, 1982	
3. SEX Male		2b. HOUR 4:30	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	
5. DATE OF BIRTH MONTH DAY YEAR April 26, 1922		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 922 Hammonds Lane	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal 21225	
13b. COUNTY AA		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 922 Hammonds Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Parker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lura R. Cress	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 3/4/41 to 224-26-3137	
17. INFORMANT ADDRESS Violet King Parker, Same as 13			
18. CAUSE OF DEATH 5/6/41 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Artery Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Depression Cerebro Vascular Accident</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DEGREE <u>Michael Schwartz MD</u>		22c. DATE SIGNED u/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Michael Schwartz		22e. ADDRESS 606 Hammonds Lane, Baltimore, MD 21225	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24 Nov 82	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA Maryland	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR NOV 23 1982	
25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u>			

MEDICAL CERTIFICATION



2025 OCT 10 10:00 AM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

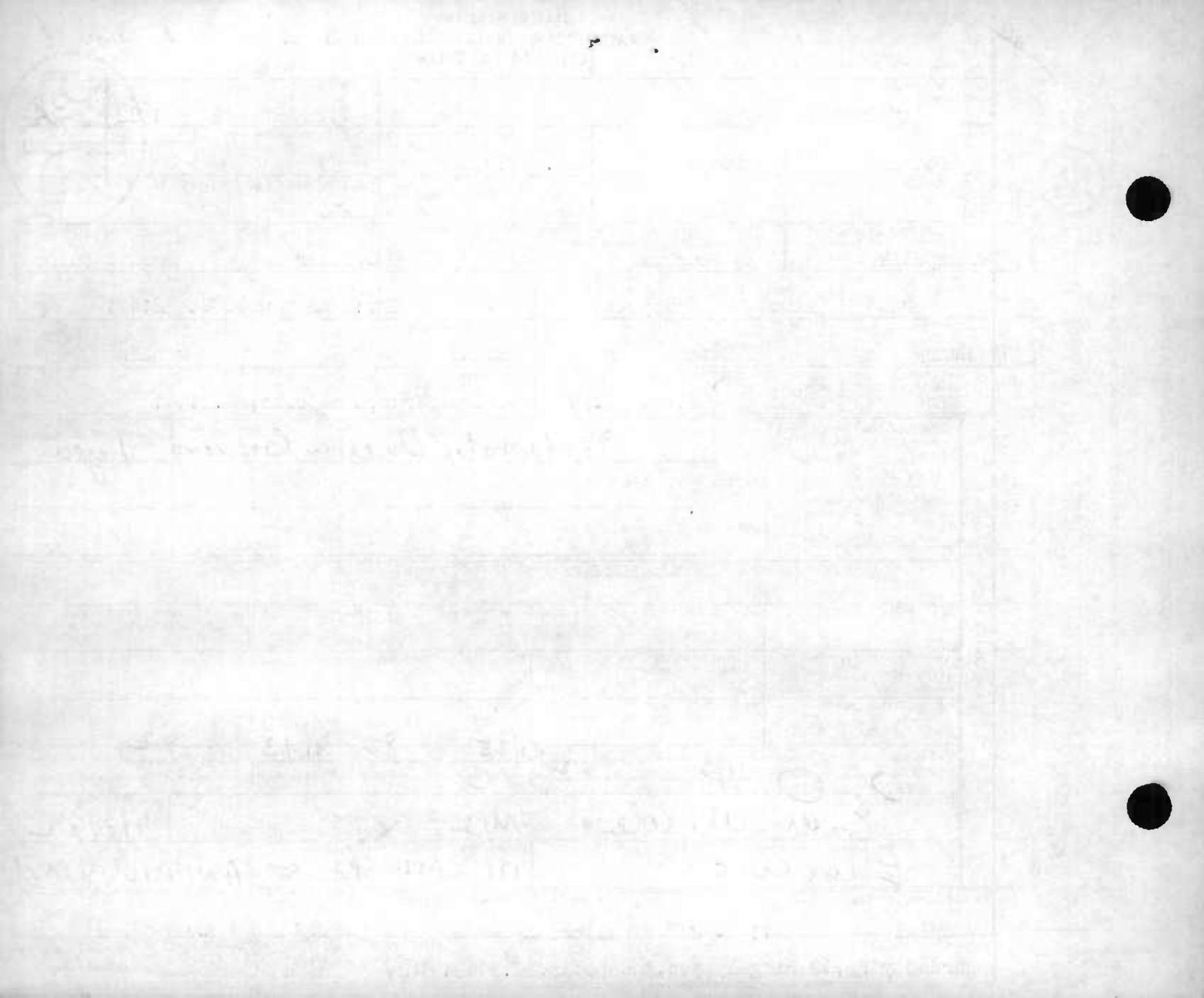
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 3 7			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
MARGARET BUSER PARKS				NOVEMBER 2 1982			
3. SEX Female		4. RACE White		5. DATE OF BIRTH OCT. 8, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AACo MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) officer		12b. KIND OF BUSINESS OR INDUSTRY Credit Union	
13a. STATE Md				13b. COUNTY AACo		13c. CITY OR TOWN Annapolis	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 912 Ridgewood St 21401			
14. FATHER'S NAME Henry Buser Sr				15. MOTHER'S MAIDEN NAME Elise Mohler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 18 5279		17. INFORMANT ADDRESS Gordon Parks, Annapolis, Md. 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ovarian Carcinoma</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>1830</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 year</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> 19 <u>82</u> to <u>11/3</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. W. COLE				DEGREE MD		22c. DATE SIGNED 11/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE				22e. ADDRESS 121 CATHEDRAL ST ANNAPOLIS Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-4-82		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AACo Md	
24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR NOV 3 1982			
				25b. REGISTRAR'S SIGNATURE John J. Carver			

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 3 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Marian Patterson</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8 Nov. 1982</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 13 1924</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME OR INSTITUTION, GIVE STREET ADDRESS) <b>180 Woods Drive</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrator</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>State Gov't.</b>
13a. STREET <b>180</b>		13b. CITY OR TOWN <b>Annapolis</b>	13c. STREET ADDRESS <b>180 Woods Drive 21403</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Valentine Ritchie</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Neumann</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>399-18-9650</b>	
17. INFORMANT <b>Francis M. Patterson</b>		ADDRESS <b>Same as #13</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral edema</b> 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Glioblastoma multiforme</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION <b>20 Aug. 1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain Tumor</b>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <b>Dr. N.P. Kitrinos</b> attended the deceased from <b>8 Nov. 1982</b> to <b>8 Nov. 1982</b> , that (1) <b>lost</b> saw the deceased alive on <b>8 Nov. 1982</b> , and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above, (1) <b>viewed</b> the body after death.			
22b. SIGNATURE <b>N.P. Kitrinos M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N.P. KITRINOS M.D.</b>		22e. ADDRESS <b>121 CATHEDRAL ST. ANNAPOLIS, MD 21401</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-11-1982</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD.</b>	
24. FUNERAL DIRECTOR NAME <b>John M. Layton &amp; Sons</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Layton</b>			

BP

1911  
March 1st  
O. A. B. 12

Wisconsin  
USA  
Hospital  
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St. Louis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 2 7 8 3 9	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
REG. NO.			EST			
1. DECEASED NAME (TYPE OR PRINT) FRANK W. PEGG			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 10, 1982		2b. HOUR 5:30P <sub>M</sub>	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 25 1910	6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10 CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steamfitter	12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY A.A.			
13c. CITY OR TOWN Riviera Bch.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 8459 Main Ave. (21122)						
14 FATHER'S NAME FIRST MIDDLE LAST Frank		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-03-3698		17. INFORMANT ADDRESS Sylvia Pegg (same as 13e)		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoxemia - Cachexia</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Melanoma to liver - Bone metastases</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 2, 1982</u> to <u>Nov 10, 1982</u> , that (I) (we) lost saw the deceased alive on <u>Nov 10, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Benito Martinez M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Nov-17-82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO MARTINEZ, M.D.		22e. ADDRESS 2932-A MOUNTAIN ROAD PASADENA, MD. 21122				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/15/82		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Jesus		
23d. LOCATION CITY OR TOWN Baltimore		COUNTY Baltimore		STATE Md.		
24. FUNERAL DIRECTOR NAME George J. Gonce		F.H. 4001 Ritchie Hgwy.		25a. DATE REC'D. BY REGISTRAR NOV 16 1982		
25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>						



10 22 1910

St. Louis, Mo.

1000 - 1st Ave. (S.W.)

1000 - 1st Ave. (S.W.)

1000 - 1st Ave. (S.W.)

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1000 - 1st Ave. (S.W.)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

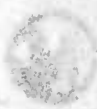
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
JOYCE LEE PFEIFER			11 13 1982			11 13 1982		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Female	White	6/15/1964	18 YRS.			11 13 1982		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Anne Arundel County		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel Hospital			Counter Lady		Fast Food	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland			A. A.	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	231 Carroll Road		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				
Charles Wallace Pfeifer				Mary Cecelia Beecher				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no			217-88-7508		Charles Pfeifer same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Atlanto-occipital separation</u>								
8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) _____								
DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			12:25x 11-13-1982		Driver in auto/auto collision.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			road		Rt. 2 near Cedar Hill Lane Anne Arundel Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
			M.D. Assistant MEDICAL EXAMINER				11-13-82	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		11/16/82		Glen Haven Mem. Pk		Glen Burnie, A. A. Md.		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Raymond C. Fink				Glen Burnie, Md.		NOV 16 1982		



9381 KOTTS

TO : DIRECTOR, FBI (100-374301) FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible] (NY 100-100000) (P)

RE: [Illegible] (NY 100-100000) (P)

DATE: [Illegible] (NY 100-100000) (P)

BY: [Illegible] (NY 100-100000) (P)

FOR: [Illegible] (NY 100-100000) (P)

THRU: [Illegible] (NY 100-100000) (P)

INFO: [Illegible] (NY 100-100000) (P)

ADVISE: [Illegible] (NY 100-100000) (P)

NOTE: [Illegible] (NY 100-100000) (P)

ADMIN: [Illegible] (NY 100-100000) (P)

FILE: [Illegible] (NY 100-100000) (P)

SEARCHED: [Illegible] (NY 100-100000) (P)

SERIALIZED: [Illegible] (NY 100-100000) (P)

INDEXED: [Illegible] (NY 100-100000) (P)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 3 4 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <del>XXXXXX</del> , EFFIE Poole				2a. DATE OF DEATH MONTH DAY YEAR 11 / 2 / 82		2b. HOUR 4:10 P M	
3 SEX Female	4 RACE CAUCAS.	5 DATE OF BIRTH MONTH DAY YEAR 3 10 1888	6 AGE (IN YEARS LAST BIRTHDAY) XXXX 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN XX XX XX		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10 CITY OR TOWN OF DEATH Millersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KNOLLWOOD MANOR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE VA.		13b. COUNTY ---	13c. CITY OR TOWN NEWPORT NEWS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 427 NICE WOOD	
14. FATHER'S NAME FIRST MIDDLE LAST John - Trammell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Gockrell <del>XXXXXX</del>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 229 36 1013		17 INFORMANT ADDRESS Wilson H. Poole, 427 Nicewood, Newport News, VA			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY 5609 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>disturbance of balance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular destruction</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 month</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>Sept 21</u> , 19 <u>81</u> , to <u>Nov 2</u> , 19 <u>82</u> , that (2) (we) lost saw the deceased alive on <u>OCT 15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Barry R. Nathanson</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON M.D.		22e. ADDRESS 1438 REFENSE HWY GAMBRIUS, MD 21054					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/82		23c. NAME OF CEMETERY OR CREMATORY Dranesville U. Meth. Herndon Fairfax Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME J. Berkley Green, 721 Elden St., Herndon, VA		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 8 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

NEW YORK

SEP 25 1900

TO THE EDITOR OF THE NEW YORK TIMES

DEAR SIR

Yours of the 24th

has been received

and I am sorry to hear that you are not well

I hope you will soon be better

I am, Sir, very respectfully,

Yours very truly,

Wm. Brewster

100 West 42nd Street, New York

Enclosed find a check for \$10.00

for the subscription to the New York Times

for the year 1901

I am, Sir, very respectfully,

Yours very truly,

Wm. Brewster

100 West 42nd Street, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

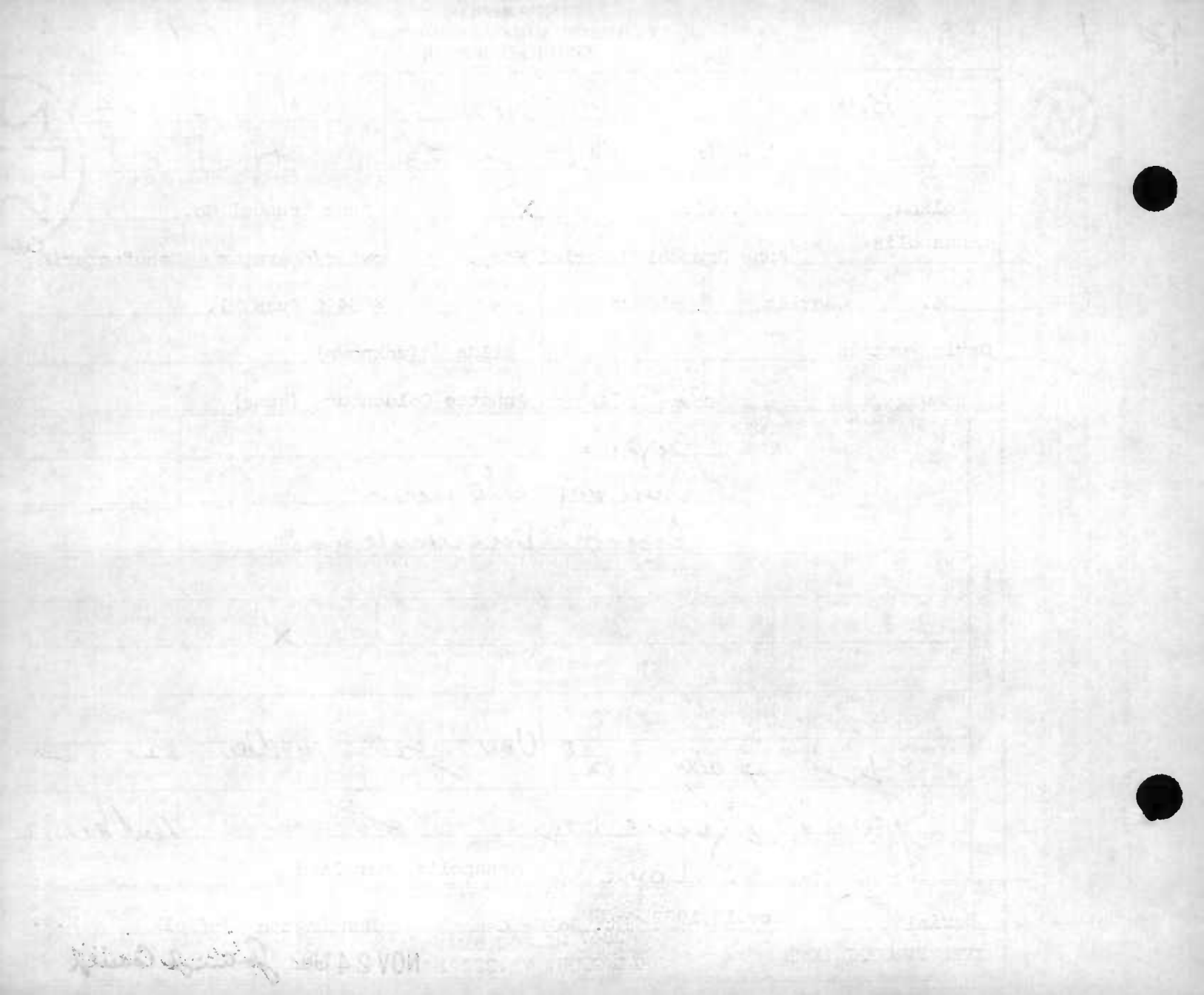
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above, any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 7 8 4 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
BENJAMIN		Postman						Nov. 16 '82		4:45	AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
MALE	WHITE		OCT. 04 '83		99 YRS.		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Poland		U.S. Cit.				Anne Arundel Co. MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel Memorial Hosp.		owner/operator		Manufacturing Co							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Md. Charles Waldorf				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4554 C Ryan Pl.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
David Postman		Hilda (unknown)		no		265-78-8955		Annette Goldenburg (same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5621 IMMEDIATE CAUSE (a) <u>Supria</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) <u>Pneumoperitoneum</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Probable Diverticulosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET		CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Nov</u> , 19 <u>82</u> , to <u>16 Nov</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>15 Nov</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
<u>Jon B. Lowe MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				<u>16 Nov 82</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
JON B. LOWE MD		Annapolis, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR					
Burial		Nov. 19, 1982		Mt. Golda Cem		Huntington, Suffolk		NOV 24 1982					
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. REGISTRAR'S SIGNATURE									
IVES FUNERAL HOME		2847 WILSON BLVD ARLINGTON, VA. 22201		<u>John J. Lowe</u>									

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

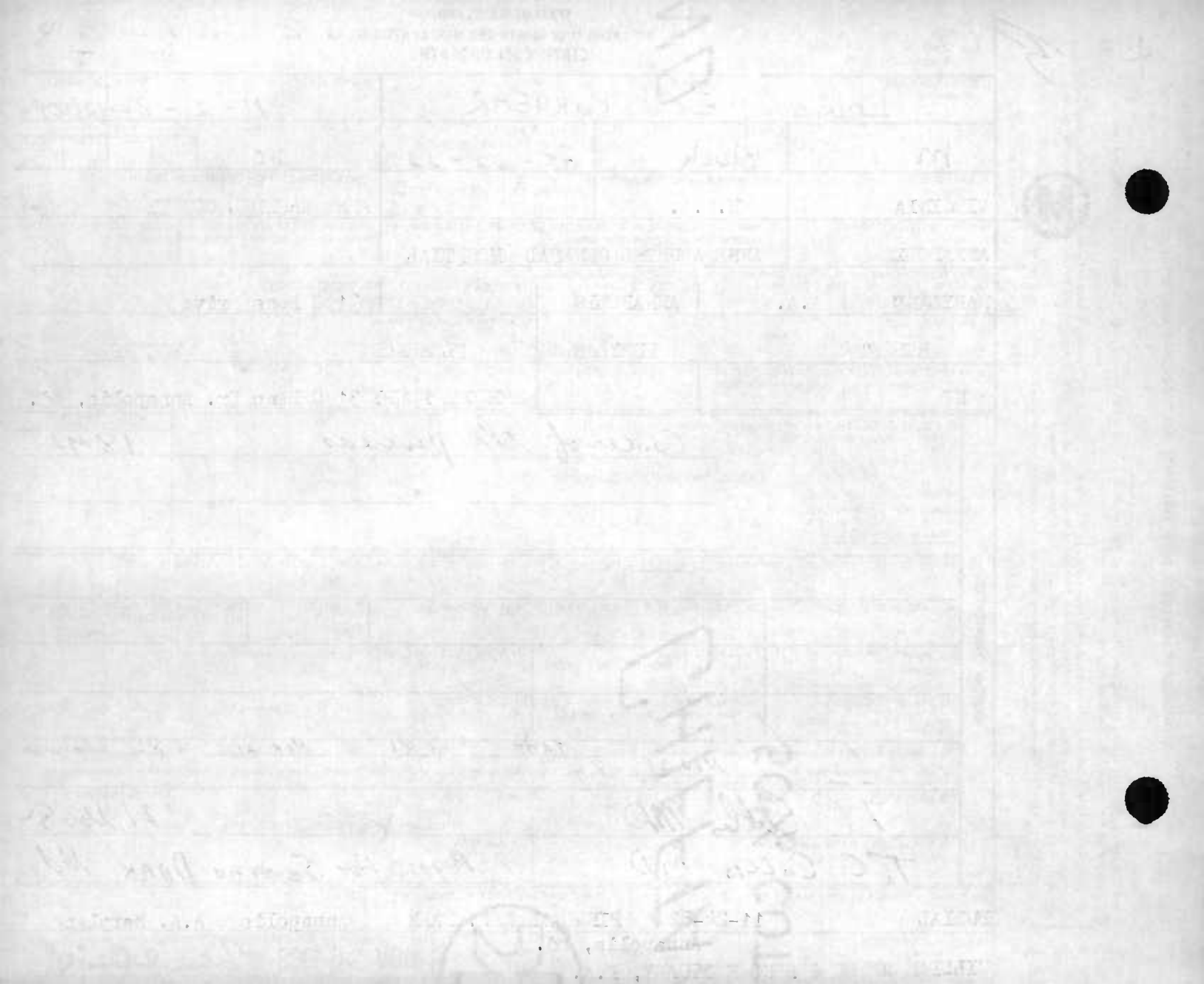
BP.

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 4 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS E. PURYEAR</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-21-82</b> 2b. HOUR <b>12:20P.M.</b>			
3. SEX <b>m</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05-22-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT PURYEAR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE ROGERS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>REBECCA PERRY 31 C Bens Dr. Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the pancreas</b> <b>1579</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>Jane</b> 19 <b>81</b> to <b>Nov 21</b> 19 <b>82</b> , that (we) lost <b>saw</b> the deceased alive on <b>Nov 21</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J.C. Callis MD</b>				DEGREE		22c. DATE SIGNED <b>21 Nov 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.C. Callis MD</b>				22e. ADDRESS <b>7-Riggs Ave Severna Park Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-24-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 4 4			
1. FOR STATE REGISTRAR Zip-21401				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Preston Oliver Raikes				MONTH DAY YEAR HOUR 11 30 82 10 <sup>10</sup> P M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 10 22		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver - Owner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN ALLEN Raikes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA Castow		16. STREET ADDRESS 11 Gilmer 21401			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-2511		17. INFORMANT HAZEL I. Raikes Sampas 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordae Aneur. 0384 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Septic Shock - 12 hrs - (c) Gram Negative Sepsis - 24-48 hrs - PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pancytopenia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from 19 772 to 11/30 82, that (I) (we) last saw the deceased alive on 11/30 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Rodney L. Brim Hall MD				22c. DATE SIGNED 12/1/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney L. Brim Hall	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-2-82		23c. NAME OF CEMETERY OR CREMATORY Md NATIONAL LAUREL	
24. FUNERAL DIRECTOR C.E. Hicks				25. DATE REC'D BY REGISTRAR DEC 13 1982		26. ADDRESS 1419 Forest Dr. Annapolis-Md	

1901-1902

Alton

Oliver R. Baker

Male

W. A. A.

Alton, Ill. - same as above - Oliver R. Baker

W. A. A. - Alton, Ill. - same as above

Alton, Ill. - same as above

Alton, Ill. - same as above

Alton, Ill. - same as above

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Alton, Ill. - same as above

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 4 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Nathan Reding</b>				2a. DATE OF DEATH <b>11/1/1982</b>		2b. HOUR <b>3:09 A.M.</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH <b>11/11/1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balt. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>cab driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Reding</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Osherov</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-05-2014</b>		17 INFORMANT ADDRESS <b>Etah K. Reding same as 13e.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH 8</b> 19 <b>75</b> , to <b>NOV 1</b> 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>OCT 31</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.							
22b. SIGNATURE <b>MW Goodman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-1-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MW GOODMAN</b>				22e. ADDRESS <b>104 FORBES ST ANNAPOLIS MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kneseth Israel Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis, Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

BP

19 NOV 1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 0202.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 7 8 4 6					
1. FOR STATE REGISTRAR					REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Mildred T Riggs					11			11		82		1235		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR		IF UNDER 1 YEAR		IF UNDER 1 YEAR	
Female		White		Sept 13, 1910		72		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
North Carolina		USA				Clement Greenleaf MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Clement Greenleaf Gen. Hospital										Compensation Bd. U.S. Govt.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		A.A.Co		Churchton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5626 Exeter St. 20733							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME										
Alvin Edward Tingle					Eva Edwards										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
NO					577-52-3866					David Riggs 851 Holly Ave Edgewater Md 21037					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
					HOUR A.M. MONTH DAY YEAR										
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11/11/82 to 11/11/82, that (1) (we) last saw the deceased alive on 11/11/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE					DEGREE					22c. DATE SIGNED					
Euse W Coley					MD					11/12/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS										
E W COLEY III					121 CATHEDRAL ST ANNAP. Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION			
Cremation					Nov. 12 1982		WESTVIEW MEM. PARK					BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR															
T.A Hardesty Annapolis Md. 21401															
25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE					
NOV 16 1982										John J. Connel					

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RECEIVED  
JAN 10 1964



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

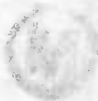
FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 4 7			
1. DECEASED NAME (TYPE COMPLETE)				2a. DATE OF DEATH				2b. HOUR			
BENJAMIN RINEHART				11-24-82				1:35 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		APRIL 9, 1906		76 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS		ANNE ARUNDEL HOSPITAL				TRAIN DIRECTOR		WASH. TERMINAL CO.			
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
MARYLAND				MONTGOMERY		SILVER SPRING YES XX NO <input type="checkbox"/>		11716 VIERS MILL ROAD 20902			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
SCOTT RINEHART				MADELINE SUMMER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				719-03-1879		MARY LOUISE RINEHART		SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
4360 IMMEDIATE CAUSE (a) Septicemia (Septicemia)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Decubitus Ulcer											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Stroke											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 23, 1982, to 27 Nov 1982, that (I) (we) last saw the deceased alive on 23 Nov 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Jon B Lowe						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		24/Nov82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Jon B Lowe						77 West St., Suite 210, Annapolis					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				10/27/82		LAKEMONT MEM. GDNS		DAVIDSON ANNE ARUNDEL MD.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS						NOV 29 1982		John J. Loefer			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.



20% COTTON

CHIEF



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Thomas Lee ROGERS, Jr.</b>										2a. DATE KNOWN OF DEATH ESTIMATED 2 11 28 1982		2b. HOUR A M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1962		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 20 YRS.		7c. DATE PRONOUNCED DEAD 11 28 1982		7d. HOUR A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel				10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electricians Helper				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland				13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1585 Dulaney Lane 21061			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Lee Rogers, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Guen Mitchell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-84-2819		17. INFORMANT ADDRESS Marjorie G. Rogers, Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8129 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Auto-Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway 9				21f. LOCATION (CITY OR TOWN, COUNTY, STATE) Ritchie Highway AA MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE E. Linhart				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 11-28-82					
EXAMINER'S NAME (TYPE OR PRINT) E. Linhart				ADDRESS Annapolis MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1 Dec 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Baltimore AA MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR NOV 30 1982				25b. REGISTRAR'S SIGNATURE John J. Connel			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 30M 2/80  
(VRA 15, 4)

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 7 8 4 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY DARBY ROPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 82</b>		2b. HOUR <b>P<sub>M</sub></b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 24 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NO. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>41 Southgate Ave</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Maryland A. A. Co. Annapolis</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>41 Southgate Ave 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES DARBY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>MARY HARPER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO -</b>	
16b. SOCIAL SECURITY NO. <b>577 52 2152</b>		17. INFORMANT ADDRESS <b>NICHOLAS J. ROPER ANNE ARUNDEL MD 21401</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Fx'd Neck</b> 3030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Fell at home</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>at home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>78</b> , to <b>29 Nov</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>25 Nov</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jon P. Lowe</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>30 Nov 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jon P. Lowe</b>		22e. ADDRESS <b>77 West St. Annapolis, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F. LINCOLN</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>BEENTWOOD P.G. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1982</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>TAYLOR FUNERAL CHAPEL ANNAPOLIS MD</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 2 2 7 8 5 0	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME				REG. NO.			
(TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH		2b. HOUR	
ARLENE F. RUFFIN				11 28 82		940 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		CAUC		7 29 22		60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Michigan		U.S.				Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel Hosp.		Homemaker			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Md.						Severna Park	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Erling Andersen				FIRST MIDDLE LAST Florence Tripp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				370-16-9987		Mr. Marvin Ruffin (Same as #13.) 21146	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 CANCER OF OVARY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/8/81, 19 to 11/28/82-19, that (I) (we) last saw the deceased alive on 11/28/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
S. P. WATKINS						11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
S. P. WATKINS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		11/29/82					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anatomy Board				Balto., Md.		DEC 7 1982	

BP

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

UNITED STATES AIR FORCE

MEMORANDUM

TO: THE SECRETARY OF THE AIR FORCE

FROM: THE CHIEF OF STAFF

SUBJECT: [Illegible]

DATE: [Illegible]

1.

2.

3.

4.

5. [Illegible]

6. [Illegible]

7.

8. [Illegible]

9.

10.

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEARLY NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAYA SAGAWA				2a. DATE KNOWN OF DEATH 11/29/82				2b. HOUR 4 P.M.			
3. SEX Female	4. RACE African American	5. DATE OF BIRTH 12/01/53	6. AGE (IN YEARS) 28 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 11/29/82	2d. HOUR 4 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Japan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. STATE Maryland				13b. CITY OR TOWN Howard		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 9343 Wheatsheaf Way			
14. FATHER'S NAME FIRST MIDDLE LAST Kiichi Sagawa				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Toshie Mikame				16. ADDRESS Columbia, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Kiichi Sagawa		17. ADDRESS 9343 Wheatsheaf Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Self-inflicted gun shot wound DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:20 P.M. 11/29/82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Glen Burnie Mall		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Glen Burnie, Maryland A.A.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Elmer G. Linhardt, M.D.				TITLE (SPECIFY) A.A. Co. MEDICAL EXAMINER		DATE SIGNED 11/29/82					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 3 Chesapeake Ave., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/1/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home 1212 West Street, Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR DEC 3 1982		25b. REGISTRAR'S SIGNATURE John J. Canine					







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 requires return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

DHM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 5 2			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNE E. Scherger</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 82</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>OCT 14 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GEN. HOSP.</b>		12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>AA.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN ELLIOTT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANE JACKSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>ELLIOTT P. SCHERGER 309 GIBSON RD ANNAPOLIS MD 21401</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute M.I.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>11/29</b> 19 <b>82</b> to <b>11/30</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rodney L. Brimhall MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/30/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rodney L. Brimhall</b>				22e. ADDRESS <b>1419 Forest Dr. ANNAPOLIS, MD, 21403</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>12-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>ANNAPOLIS AA. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>				25. DATE REC'D. BY REGISTRAR BY REGISTRAR'S SIGNATURE <b>DEC 2 1982</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Alice Margaret Schmidt		2a. DATE OF DEATH MONTH DAY YEAR 11-8-82		2b. HOUR 6:02 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 26, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Cannapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (RET.)		12b. KIND OF BUSINESS OR INDUSTRY Md. State Legislature
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4306 Mountain Road 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Sedwick Pumphrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice L. Rider			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 4304 Mountain Rd., Pasadena, Md. Mrs. Virginia E. Smith (Daughter)	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Stroke 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 Hrs. 15 yrs.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hepatitis-			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from Sept 7 Nov 19 82, to 8 Nov 19 82 that (1) (we) last saw the deceased alive on above, (1) (we) (did not) view the body after death, and that in (my) (an) opinion death occurred on the date and hour and from the causes stated			
21g. SIGNATURE Gary M. Richardson, M.D.		DEGREE M.D.	22c. DATE SIGNED 11-8-82
22a. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. Richardson		22b. ADDRESS 104 Forbes Street Annapolis, Md 21401	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10 NOV 82	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Md.
24. FUNERAL DIRECTOR NAME J. Easter		25a. DATE REC'D. BY REGISTRAR NOV 9 1982	25b. REGISTRAR'S SIGNATURE John J. Connelley
SINGLETON FUNERAL HOME, GLEN BURNIE, MD.			

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 2 7 8 5 4

 1. FOR  
 STATE  
 REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) ALICE V SCOTT			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27, 1982		2b. HOUR 9:15 a.m.
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 1 19 87		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Hanover	13c. STREET ADDRESS 7611 Ridge Rd. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST James Butler Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 064-12-3504		17. INFORMANT ADDRESS John T. Lippman 416 Morris Hill Ave.	

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART 1. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/26/82 19 to 11/27/82 19, that (I) (we) last saw the deceased alive on 11/26/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Jorge B. Ramirez		DEGREE Attending Physician		22c. DATE SIGNED 11/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D.		22e. ADDRESS 7845 OAKWOOD RD., #205 GLEN BURNIE, MD. 21061			

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

Contract for the  
construction of the  
new building at  
the University of  
California, Berkeley

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Mr. J. R. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 7 8 5 5	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	EST
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANTHONY (nmn) SEBASTIAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 18, 1982</b>			2b. HOUR <b>9:49</b> P M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 7, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pal</b> <b>Jones Dist.</b>			
13a. STATE <b>MD.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21122 8085 Woodholm Cir.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Sebastian</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Rohs</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>n/a</b>		17. INFORMANT <b>same as #13</b> <b>Mrs. Evelyn E. Sebastian -wife-</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>CV A</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHF.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/6/82</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>11/19/82</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7845 Oakwood Road #205 Glen Burnie, Maryland 21061</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6/82</b> to <b>11/19/82</b> that (I) (we) lost saw the deceased alive on <b>11/19/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I did not view the body after death.											
22b. SIGNATURE <b>George B. Ramirez, M.D.</b>					DEGREE <b>MD.</b>			22c. DATE SIGNED <b>11/19/82</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>22 Nov. 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>					25a. RECEIVED BY REGISTRAR <b>NOV 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lewis</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified of page 58.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 2 7 8 5 6				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
George Secunda					11 27 82				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
MALE		C		4 17 11		71 YRS.		11 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Mass		U.S.				Anne Arundel MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Severna Park		Meridan Nsg Ctr				Army Air Corps			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Md		IAA		Arnold		454 Century Vista Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Morris Secunda		Rose Lerner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		016-05-4936		Ronald Secunda		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 82, to 11/27 19 82, that (I) (we) lost above the deceased alive on 11/27 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)		22b. SIGNATURE Thomas Walsh MD DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED 11-28-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS M. WALSH MD		22e. ADDRESS 269 Peninsula Farm Rd. Arnold Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 Nov. 82		23c. NAME OF CEMETERY OR CREMATORY Beth El Jacob Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Guilderland Albany New York			
24. FUNERAL DIRECTOR NAME James S. Kirkley F.H. Glen Burnie -MD.		25a. DATE REC'D. BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE John J. Gough					

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JAN 10 1941  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

(M)



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CHIEFMAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE DELETED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27857		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR			
Mike Leroy Siegert						11 17 19 82			M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	June 29, 1959	23 YRS.			11 17 19 82			8:25 A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.				Anne Arundel County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Millersville		Rt. 3 Northbound				Restaurant Mgr.		Hardee's				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			
			Maryland			Anne Arundel			Glen Burnie			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Howard Daniel Siegert			Alice Doering						110 5th Avenue S.E. 2nd fl.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT - wife - ADDRESS			same as # 13			
Yes			1976 - 1980			219-76-1870			Mrs. Eleanor Marie Siegert			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
8150 IMMEDIATE CAUSE (a) Asphyxia												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
				? P.M. 11 17 1982				Driver in auto/fixed object impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				
				street				Rt. 3 Northbound, Millersville, A.A.CO., Md.				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
TITLE (SPECIFY) Deputy Chief												
ACTUAL SIGNATURE				DATE SIGNED				11/17/82				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Thomas D. Smith, M.D.				111 Penn St. Balto., Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY STATE	
Burial			20 Nov. 82		Loudon Park Cemetery			Baltimore,			MD.	
24. FUNERAL DIRECTOR				25. REC'D. BY REGISTRAR				26. TRADE'S SIGNATURE				
Name: Glen Burnie, Maryland				NOV 23 1982				John J. Chief				

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

NOV 1964





## CERTIFICATE OF DEATH

8 2 2 7 8 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Barbara Kay Smith			2a. DATE OF DEATH MONTH DAY YEAR November 17 1982		2b. HOUR 8:50a <sub>M</sub>		
3. SEX Female		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR December 15 1941		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Brighton, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Ft. Meade, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Relman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Bauer		16. STREET ADDRESS 7901 S. Cartier Court/Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT ADDRESS Husband - Donald E. Smith same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERCALCEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC BREAST CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>1749</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Harry Saunders</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 NOV 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Saunders, CPT, MC				22e. ADDRESS Kimbrough Army Community Hospital, Ft. Meade/			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/20/82		23c. NAME OF CEMETERY OR CREMATORY Sylvania Hills Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Rochester, Pa.	
24. FUNERAL DIRECTOR Hardesty Funeral Home				25a. DATE REC'D. BY REGISTRAR NOV 18 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

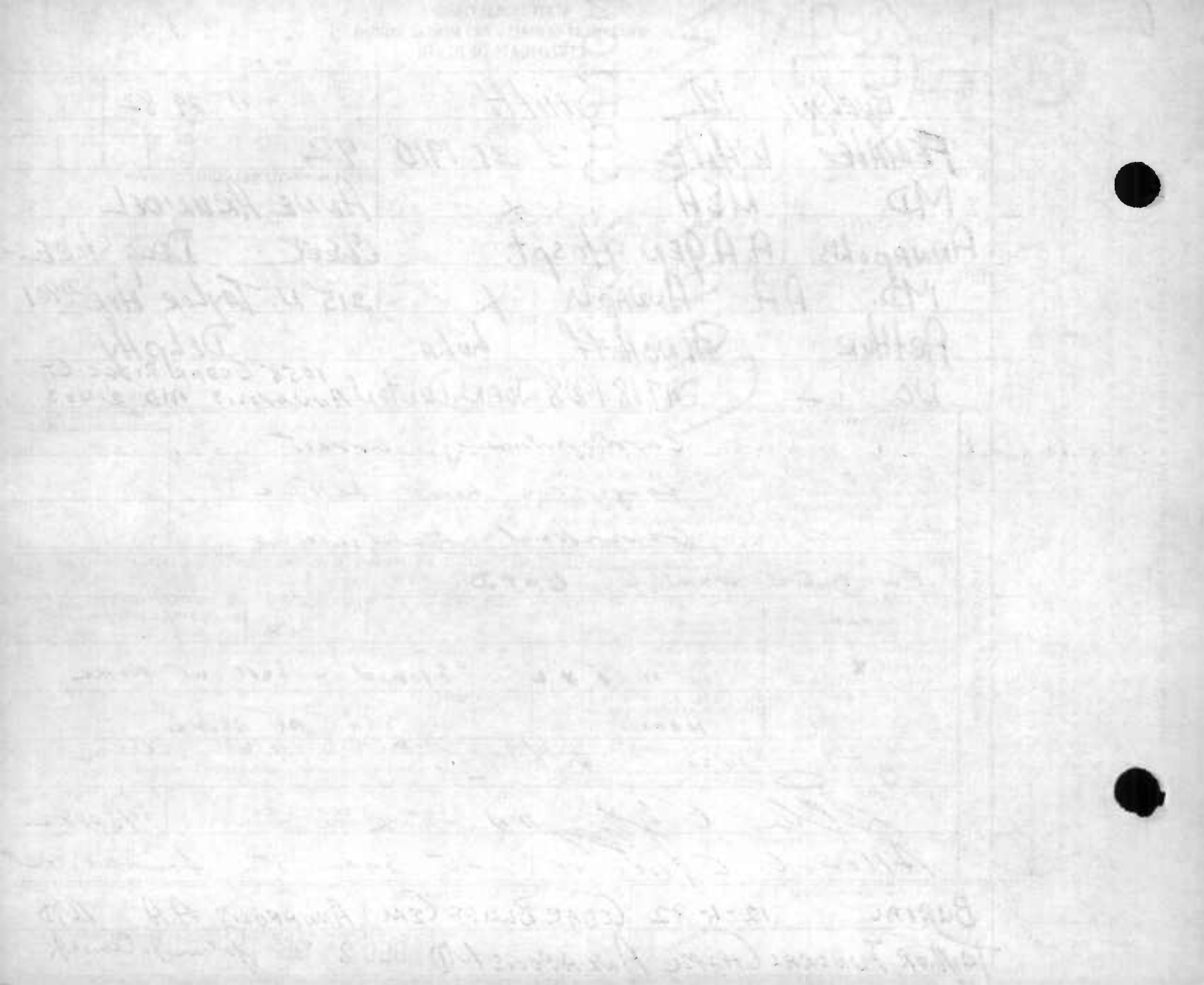
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EVELYN M. SMITH</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>29</b> YEAR <b>82</b>			2b. HOUR <b>M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>31</b> YEAR <b>1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.H. GEN. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>			
13a. STATE <b>MD.</b>		13b. COUNTY <b>HA</b>		13c. CITY OR TOWN <b>ANNAPOIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (TYPE OR PRINT) <b>Arthur</b>		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>DELPHY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217181908</b>		17. INFORMANT <b>JOAN DUNTON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fx Pulv. Vami. - C.O.R.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>11 9 8 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <b>Slipped + fell at home</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>Same as Above</b> CITY OR TOWN <b>ANNAPOIS</b> COUNTY <b>ANNE ARUNDEL</b> STATE <b>MD.</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> 19 <b>82</b> , to <b>11/29</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/28</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (do not) view the body after death.		22b. SIGNATURE <b>Allen C. Egloff MD.</b>		DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen C. Egloff MD.</b>		22e. ADDRESS <b>25 Shaw St. Annapolis Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-1-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF CEM.</b>		23d. LOCATION (CITY OR TOWN) <b>ANNAPOIS MD.</b>			
24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>Taylor Funeral Chapel</b>		ADDRESS <b>ANNAPOIS MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 2 7 3 6 0				
1. DECEASED NAME (FIRST, MIDDLE, LAST) <b>Katerine Bertha SMITH</b>					2a. DATE OF DEATH (MONTH, DAY, YEAR) <b>November 6, 1982</b>			2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH, DAY, YEAR) <b>Jan. 27, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21122 317 Brookfield Road</b>	
14. FATHER'S NAME (FIRST, MIDDLE, LAST) <b>Daniel Vogelsang</b>				15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <b>Bertha Borkman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212.14.2476</b>		17. INFORMANT (NAME, ADDRESS) <b>Kathleen J. Shires 1516 Hazel St. Baltimore</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>4100 IMMEDIATE CAUSE (a) myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>diabetes mellitus - 3 weeks</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/5</b> 19 <b>82</b> to <b>11/6</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>10/12</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R.M. McLaughlin, M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/7/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Randall McLaughlin, MD</b>				22e. ADDRESS <b>Pasadena, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>NOV. 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie AA Md</b>			
24. FUNERAL DIRECTOR (NAME, ADDRESS) <b>Singleton Funeral Home, Glen Burnie, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 6 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				REG. NO.			
LULA H. SMITH				11 4 82				11:22 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		CAYC		1 13 24		58 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA		USA				Anne Arundel MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Annapolis				Anne Arundel General				Retired Home Markets			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD				AA		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		200 President Street 21403	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Henry Hurd				Church							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				215-247-780		Howard L. Smith		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b) Hypertension, Adeno Car - lung											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 1977, to present 1982, that (I) (we) lost saw the deceased alive on 5/18/82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) did not see the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Key Samaras								11/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
George P. Samaras				205 Ridgely Ave Annapolis MD							
23a. BURIAL, CREMATION, REMOVAL (BY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Nov. 8, 1982		Cedar Bluff		Annapolis AA MD			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Taylor & Sons - Annapolis, MD						NOV 10 1982		John J. Smith			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 6 2			
1. FOR STATE REGISTRAR 21403(ZIP)				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH MARY SPRIGGS				2a. DATE OF DEATH MONTH DAY YEAR 10-8-82			
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 7-18-23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Lumpkin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel County Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WEEK) L.P.N. Retired Gen.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth W. H. PPLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION Henrietta STEPNEY		16. STREET ADDRESS 908 Windsor Ave 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-18-5162		17. INFORMANT ADDRESS ALbert Spriggs - Same As 13 E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis 5715 DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-Renal Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Cryptogenic Embolism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8 Nov 19 79, to 8 Nov 19 82, that (I) (we) last saw the deceased alive on 8 Nov 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Jon B. Lowe, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 Nov 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon B. Lowe, MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-12-82		23c. NAME OF CEMETERY OR CREMATORY Md Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md	
24. FUNERAL DIRECTOR NAME C. E. Hicks				24b. ADDRESS ANNAPOLIS - MD		25a. DATE REC'D. BY REGISTRAR NOV 18 1982	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

E.S.T.

1. DECEASED NAME (TYPE OR PRINT) DIXIE MAY SPRUILL			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 22, 1982		2b. HOUR 02:37AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Wrapper		
12b. KIND OF BUSINESS OR INDUSTRY Food		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		
13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8378 Oakwood Rd. 21108		
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Geneva		16. ADDRESS Anderson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-30-7045		17. INFORMANT Ivin Spruill		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissecting aortic aneurysm, type B</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M.D.		DEGREE Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		22c. DATE SIGNED 11/22/82		
22d. ADDRESS 7845 OAKWOOD ROAD SUITE 107 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/24/1982		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		
23d. LOCATION CITY OR TOWN Donsey		COUNTY Howard		STATE Md.		
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Pasadena		ADDRESS Mtn. & Tick Neck Rd., Pasadena, Md. 21122		25a. DATE REC'D BY REGISTRAR NOV 24 1982		
25b. REGISTRAR'S SIGNATURE John J. Connel						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of or certified by the medical examiner.



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MADE IN  
USA



MADE IN USA  
100% COTTON  
MADE IN USA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 6 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles M Stearns</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/25/82</b>		2b. HOUR <b>3 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 1 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>H.A.</b>	13c. CITY OR TOWN <b>West River</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4903 E. Chalk Point Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Myron Stearns</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Gibbons</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>055-16-5805</b>		17. INFORMANT ADDRESS <b>Mrs. Caroline Stearns (Same as #13.)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF HEAD + NECK</b> <b>1734</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19/82</b> , 19____, to <b>11/25/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/24/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>STANLEY P. WATKINS</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M Watkins</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 30 1982</b>		23f. REGISTRAR'S SIGNATURE <b>J. G. G. G.</b>	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 6 5 REG. NO. E.S.T.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MAY STEPHENSON				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 24, 1982				2b. HOUR 12:40 <sup>M</sup>
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		
12b. KIND OF BUSINESS OR INDUSTRY Litho Supply		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN AA		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13d. STREET ADDRESS 115 Martha Road 21061		14. FATHER'S NAME FIRST MIDDLE LAST Elmer E. Byers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 200-14-2123		17. INFORMANT ADDRESS Gerald Stephenson, Husband, same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4860</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia Empyema</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24/1982</u> to <u>11/24/1982</u> , that (I) (we) last saw the deceased alive on <u>11/23/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL V. CYRIAC, M.D.		22e. ADDRESS 7445-A FURNACE BRANCH ROAD GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 27 Nov. 82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Md.		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 6 6			
1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E Sunder-land				2a. DATE OF DEATH MONTH DAY YEAR 11/27/82		2b. HOUR 732 M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct 24 1892		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5593 Greenock Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md AA Bethesda				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5593 Greenock Rd 20711	
14. FATHER'S NAME FIRST MIDDLE LAST Ashbey Sunder-land				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Wood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				16b. SOCIAL SECURITY NO. 220 562 05		17. INFORMANT ADDRESS Edwina Sheppard same co #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4292 Cerebral anoxia - DUE TO, OR AS A CONSEQUENCE OF (b). Cardiac failure - DUE TO, OR AS A CONSEQUENCE OF (c). Cardiovascular disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH formed. yes -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Stroke, Diabetes							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 15 Nov 1982 to 27 Nov 1982, that (I) (we) last saw the deceased alive on 15 Nov 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William H Chute, MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 30, 82		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda AA Md	
24. FUNERAL DIRECTOR NAME Nawach Funeral Home				ADDRESS Dwings md		25a. DATE REC'D. BY REGISTRAR DEC 6 1982	
				25b. REGISTRAR'S SIGNATURE John J. Conner			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 7 8 6 7	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE J. SUWALSKI						2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 28, 1982			2b. HOUR 8:14 am		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 11 93		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) landlord		12b. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.			
13a. STATE Md.				13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 940 Pier Point Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen J. Suwalski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Philomena R. Dulje							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 219-32-1229		17. INFORMANT Pasadena, Md. 21122 Louise Cassell 940 Pier Point Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> 5325 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic heart failure and peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Perforated duodenal ulcer with peritonitis.</u>											
19a. DATE OF OPERATION 11-19-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated duodenal ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-19-82</u> , 19 <u>82</u> , to <u>11-28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul M. Rosoff</u> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-28-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL M. ROSOFF, M.D.						22e. ADDRESS 7575 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/2/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN		COUNTY		STATE Md.	
24. FUNERAL DIRECTOR NAME Geo. J. Gonce F.H. 4001 Ritchie Hwy 21225						25a. DATE REC'D. BY REGISTRAR DEC 1 - 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Gonce</u>			

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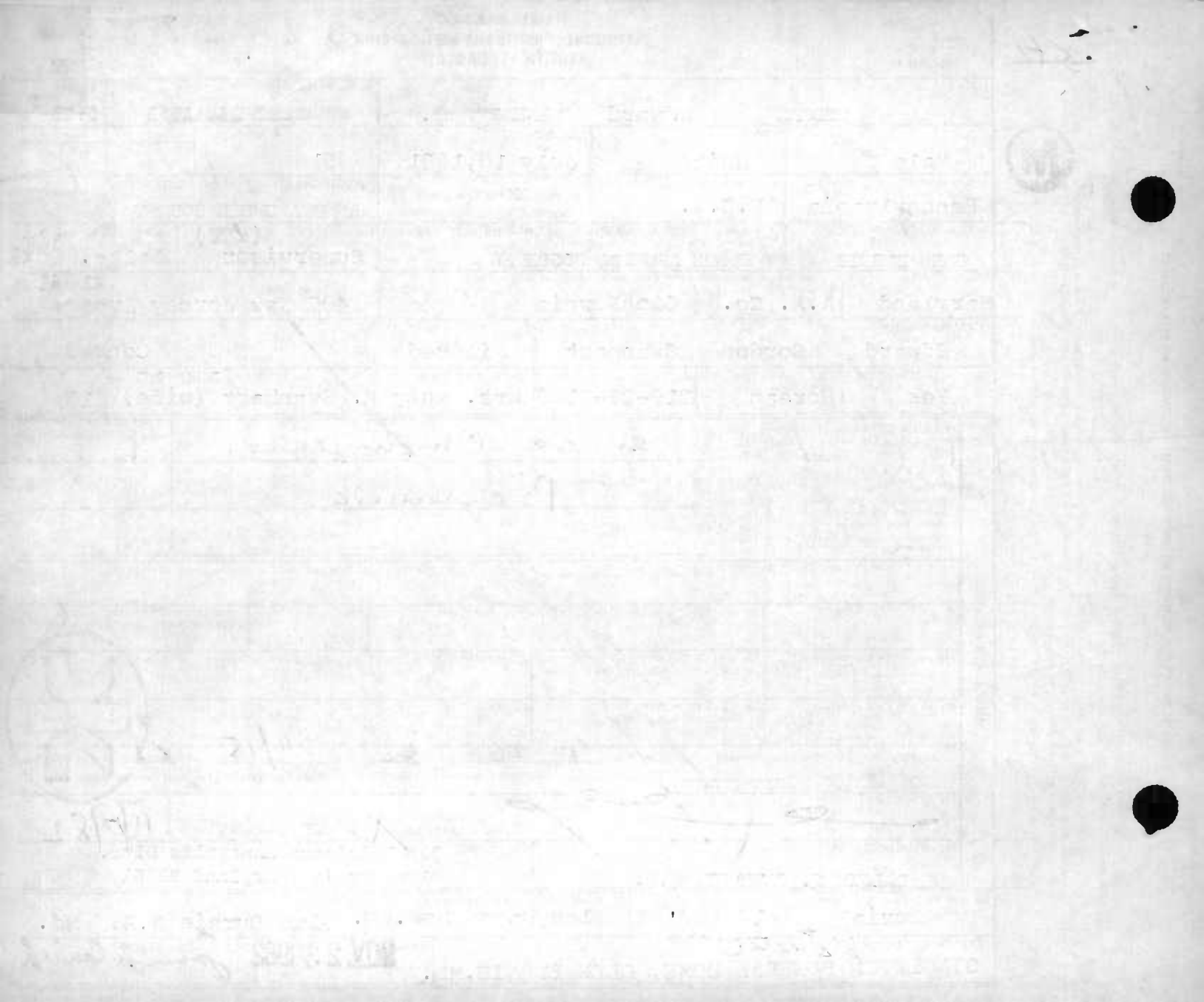
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	2	7	8	6	8
1- FOR STATE REGISTRAR										REG. NO.				EST		
1 DECEASED NAME (TYPE OR PRINT) THOMAS Edward SWANHART, SR.										2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 15, 1982				2b. HOUR 5:25 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.						
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.										
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (RET.) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Balto. Coil								
13a. STATE Maryland				13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 405 New Jersey Avenue				21061		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Gordon Swanhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Conrad												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs. Ruby K. Swanhart (wife)		ADDRESS Same as # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cause Emphysema.</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pneumonia.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>82</u> , to <u>11/15</u> , 19 <u>82</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>[Signature]</u>										22c. DATE SIGNED 11/15/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY, M.D.										22e. ADDRESS 205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 18 NOV'82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.						
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.										25a. DATE OF DAY REGISTRATION NOV. 23 1982						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 7 8 6 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>EARL L. SWAUGER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 9 82</b>			2b. HOUR <b>0200</b>			
3. SEX <b>M Male</b>		4. RACE <b>W White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-10-15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>917 Reese Road 21144</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Swauger</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Livengood</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Wife, same as 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY: <b>5000 IMMEDIATE CAUSE (a) pulmonary hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Black lung disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 month</b> <b>20 year</b> <b>30 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>11-8</b> , 19 <b>82</b> , to <b>11-9</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>11-8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Peter Schilber</b> MD					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-9-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER SCHILBER</b>					22e. ADDRESS <b>25 SHAW ST ANNAPOLIS MD 2140</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>13 Nov. 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, AA, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>				

BP







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VRA 15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH ELI TONGUE</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/20/82</b>			2b. HOUR <b>6:59</b>		
3. SEX <b>M</b>	4. RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar 15 1937</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>45 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/20/82</b>	2d. HOUR <b>8:00</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>			
10. CITY OR TOWN OF DEATH <b>HARWOOD</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4565 MUDDY CREEK ROAD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Land Fill</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>HARWOOD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4565 MUDDY CREEK RD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELI TONGUE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KAYHERINE TONGUE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219 34 4894</b>		17. INFORMANT ADDRESS <b>EDITH TONGUE 4565 MUDDY CREEK RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>			M.D. <b>A.A.CO.</b>			MEDICAL EXAMINER		DATE SIGNED <b>11/20/82</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Elmer G. Linhardt, M.D.</b>			ADDRESS <b>3 Chesapeake Ave., Annapolis, Md. 21403</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 24 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chews Church</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owensville Agassiz Md</b>		
24. FUNERAL DIRECTOR NAME <b>C.E. Hicks</b>			ADDRESS <b>11k 1922 Forest Drive</b>			25a. DATE REC'D. BY REGISTRAR (2b. REGISTRAR'S SIGNATURE) <b>NOV 29 1982</b>		

FILE

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Land Will  
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Leicester

4500 WOOD STREET ROAD

HAWOOD

X 4500 WOOD STREET ROAD

HAWOOD

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KAYBRIE

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FILE

SID 24 4500 WOOD STREET ROAD

Nov 24 1937  
Crawsville A.A.  
Nov 24 1937  
Crawsville A.A.  
Nov 24 1937  
Crawsville A.A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 7 EST!

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NAOMI RUTH TURNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 1, 1982</b>		2b. HOUR A <b>11:30 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Frederick, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USVA OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Payroll Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Brooklyn Pk.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>407 E. Walton Ave. 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter DeLauter</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myra Whipp</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No Na</b>		16b. SOCIAL SECURITY NO. <b>216-10-3919</b>	17. INFORMANT (son) ADDRESS <b>Mr. Raymond D. Turner 1515 Chapel Hill Dr. (21237)</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1539  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PULMONARY EDEMA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CARCINOMA OF COLON WITH METASTASIS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE - COPD**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29/82</u> to <u>11/1/82</u> that (I) (we) last saw the deceased alive on <u>10/30/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>M. Khodabandelou</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>11/1/82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MOHAMMAD KHODABANDELOU, M.D.</b>		22e. ADDRESS <b>1101 PATAPSCO AVE., BALTIMORE, MARYLAND</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 4, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>
24. FUNERAL DIRECTOR NAME <i>Dean F. Charlton</i>		25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1982</b>	
24. FUNERAL HOME <b>Singleton Funeral Home Glen Burnie Md</b>		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DET

NOVEMBER 1, 1953 11:30 AM

TURNER

ANN ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

ANN ARUNDEL COUNTY

ANN ARUNDEL COUNTY

ANN ARUNDEL COUNTY

ANN ARUNDEL COUNTY

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ANN ARUNDEL COUNTY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))  
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 27872			
1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED ELAINE VANAE LST</b>										2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11 19 82		2b. HOUR P M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 22 31</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>51 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 19 82</b>		2d. HOUR P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL CO.</b>	
10. CITY OR TOWN OF DEATH <b>glenburnie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North ARUNDEL Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Crofton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1461 Harrow Avenue 21114</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harvey Noyes</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Markley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-30-5656</b>				17. INFORMANT ADDRESS <b>Emil VanAelst 1461 Harrow Ave. 21114</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Just over</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>E. L. Ward</b>				TITLE (SPECIFY) M.D. <b>Deputy</b>				MEDICAL EXAMINER DATE SIGNED <b>11/19/82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>F. L. Ward MD</b>				ADDRESS <b>Annapolis, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>					

Rupert's Travel Home, Inc. 4107 Wilcox Ave.

21250

11/23/52 To: State of California, Sacramento

Re: [illegible]

11/23/52

Woodward

11/23/52



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 7 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWIN "nmn" VANOVER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 18, 1982</b>			2b. HOUR <b>9:30A M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 8, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (RET.) (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assemblyman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Genl. Motors</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron B. Vanover</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Jane Hall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>403-07-6304</b>		17. INFORMANT ADDRESS <b>Wilmington, Del.</b> <b>Mr. Eugene E. Vanover (son) 19810</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4279 S/P CRR Respiratory failure</b> IMMEDIATE CAUSE (a) <b>S/P CRR Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>11/18/82</b> , that (I) (we) lost saw the deceased alive on <b>11/18/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Hamid A. Towhidian</b> DEGREE PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAMID A. TOWHIDIAN, M.D.</b>						22c. DATE SIGNED			22d. ADDRESS <b>3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>20 NOV '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Md.</b>		
24. FUNERAL DIRECTOR <b>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</b>						25a. DATE RECEIVED BY REGISTRAR <b>NOV 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

MEDICAL CERTIFICATION



Virginia

Richmond

Richmond

Richmond

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 7 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Ruby Rosa Voelkel</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11-24-82</u>		2b. HOUR <u>6:45 AM</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11 08 08</u>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>74</u> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD.	
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>363 Kingsbury Drive</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <u>Illinois Morgan Jacksonville</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>315 S. Laurel 62650</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edward Fiedler</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Dorothea Ketting</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>			
		16b. SOCIAL SECURITY NO. <u>325'42'4406</u>		17. INFORMANT <u>Nancy Heacock</u>		ADDRESS <u>363 Kingsbury Drive Annapolis, MD 21401</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>2019</u> IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>79</u> to <u>11/22</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Enser W. Cole, M.D., P.A.</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/24/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Enser W. Cole</u>				22e. ADDRESS <u>121 Cathedral St.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov 27, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Hill</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bellerville, St. Claire, IL</u>	
24. FUNERAL DIRECTOR NAME <u>John M. Taylor &amp; Sons, Annapolis, MD</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 30 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 7 8 7 5	
1. FOR STATE REGISTRAR		REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MELVIN O WALKER				NOVEMBER 1 18 82 6 24 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. HOUR
MALE	NEGRO	NOV 23 1906	75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
NORTH CAROLINA	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		LABORER		STEEL
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS		
MARYLAND	A.A.	SEVERN	SEVERN, MD. 21144		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		
ANTHONY WALKER	ROBERTA COUSINS		217-01-0446		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO	217-01-0446		PAULINE WALKER/7820 OLD QUARTERFIELD ROAD 21144		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction				Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease				years	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 11-18-82 that (I) (we) lost saw the deceased alive on 11-17-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
JACK L. STERN M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		21061	
		300 HOSPITAL DRIVE, GLEN BURNIE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		11/22/82		Md NAT'L MEM PARK	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. LOCATION	
MARSHALL W JONES, JR		4101 EDMONDSON AVE		LAUREL COUNTY Md. STATE	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NOV 22 1982		John J. Connel			

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NOV 19 1944

TO THE DIRECTOR, BUREAU OF PRISONS

FROM THE DIRECTOR, BUREAU OF PRISONS

SUBJECT: [Illegible]

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(VR A15 ME (5))  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27876	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN W. WALLACE</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>3</b> YEAR <b>1982</b>		2b. HOUR <b>A</b>			
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>22</b> YEAR <b>1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>11 3 82</b>		2d. HOUR <b>A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ODENTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2945 Conway Road</b>			
14. FATHER'S NAME FIRST <b>BENJAMIN</b> MIDDLE <b>WALLACE</b> LAST <b>WALLACE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>BESSIE</b> MIDDLE <b>SHORTER</b> LAST <b>SHORTER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-14-3634</b>		17. INFORMANT <b>LILLIAN WALLACE</b>		ADDRESS <b>2945 Conway Rd. Odenton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>[Signature]</b>		TITLE (SPECIFY) <b>Medical Examiner</b>		M.D. <b>[Signature]</b>		MEDICAL EXAMINER		DATE SIGNED <b>11-3-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>F. LINHART</b>		ADDRESS <b>Alameda 115 - MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-6-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John A.M.E. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Odenton Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b> ADDRESS <b>Annapolis, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the State Dept. of Health and Mental Hygiene, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES ANDREW WARNER</b>			2a. DATE OF DEATH <b>11</b> Month <b>12</b> Day <b>82</b> Year			2b. HOUR <b>845 P M</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>4.25. 93</b>		6. AGE (In years last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.					
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1479 Eagle Court</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1479 Eagle Court</b>		
14. FATHER'S NAME First Middle Last <b>William Warner</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rebecca Earney</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Marie Warner</b>			Address <b>same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart FAILURE</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b> <b>2-3 yr</b> <b>year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-12-82</b> , 19 <b>82</b> , to <b>8/11/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/11</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Michael J. LaPenta</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/82</b>	
22d. PHYSICIAN'S NAME (Type) <b>MICHAEL J. LAPENTA</b>						22e. ADDRESS <b>703 GIDDINGS AVE ANNAPOLIS Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>Nov 16, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Suburban Mem Gardens</b>			23d. LOCATION (City or Town) (County) (State) <b>CONAWAGO TOWNSHIP, Pa.</b>			
24. FUNERAL DIRECTOR <b>Beall Funeral Home</b>						ADDRESS <b>1212 West St., Anna., Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	



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central station

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 7 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

E.S.T.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST WARREN			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11, 1982		2b. HOUR 11:34 AM
3 SEX Female	4. RACE Col.	5. DATE OF BIRTH MONTH DAY YEAR 7-7-23	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) St. Louis Mo.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland 13b. COUNTY H.A. 13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1618 S. Hammonds Ferry Rd.	
14. FATHER'S NAME FIRST JOHN MIDDLE S. LAST Nicholson		15. MOTHER'S MAIDEN NAME FIRST Beatrice MIDDLE DAVIS LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-18-0289		17. INFORMANT ADDRESS Mr. Ernest Warren 618 S. Hammonds Ferry Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 hour

1749  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Pulmonary metastases

18 months

DUE TO, OR AS A CONSEQUENCE OF

(c) Breast cancer

18 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Liver failure from Breast cancer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Steven Akman M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/12/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN AKMAN, M.D.		22e. ADDRESS 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 11-16-82	23c. NAME OF CEMETERY OR CREMATORY St. Kest Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE HARMONS PA Co. MD
24. FUNERAL DIRECTOR NAME Joseph L. Russ 2222 W. North Ave.		25a. DATE REC'D. BY REGISTRAR NOV 17 1982	
		25b. REGISTRAR'S SIGNATURE John J. Canick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-82

NOVEMBER 11, 1982

11-11-82

JACKSON COUNTY

NORTH ANGELO HOSPITAL

ALLEN BRANT

33 NORTH GORMAN STREET

DA. DORRIS, M.D. 21201

STEVEN ARON, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 7 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Mildred Matilda Warren				Nov. 2 82 10:30 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		3 26 16		66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Missouri		USA				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		130 Hearne Road		Housewife			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Anne Arundel		Annapolis	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
William R. Morris				Mabel M. Getz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
no				215-40-4572		Sue E. Allen	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Bronchitis							
4912 DUE TO, OR AS A CONSEQUENCE OF							
(b) Chronic Obstructive Pulmonary Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
2 wks							
1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Severe Scoliosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from July 2, 1979, to 10/27, 1982, that (I) (we) lost							
saw the deceased alive on 10/27, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
James Chaconas M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
James Chaconas				1521 Ritchie Hwy Annapolis, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial transit		Nov. 6 1982		Sunset Memorial Gardens		CITY OR TOWN COUNTY STATE	
						Lawton Oklahoma	
24. FUNERAL DIRECTOR				25a. DATE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Beall Funeral Home 1212 West St., Anna., Md.				NOV 8 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

E.S.T.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM B. WATKINS			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 9, 1982			2b. HOUR 6:23 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-7-95		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Linthicum Hgts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 317 E. Maple Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn.				16b. SOCIAL SECURITY NO. 217-05-4375		17. INFORMANT ADDRESS Mr. Frederick Koontz 1700 1st Nat'l Bank Balto., Md. 21202			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atrial clonic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 1982 to Present, that (I) (we) last saw the deceased alive on May 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE Jorge Ramirez, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/10/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 11/11/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR NOV 18 1982		25b. REGISTRAR'S SIGNATURE John J. Canale	

BP

1500

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold Jerome Weathers			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 11 29 82			2b. HOUR M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 2 34	6. AGE IN YEARS (LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 29 82	2d. HOUR 1:01 P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY K&K Refuse
13a. STATE Maryland			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ross Weathers, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Johnson			16. ADDRESS 1014 N. Rosedale St.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-30-5013			17. INFORMANT George Weathers-Baltimore, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7473 IMMEDIATE CAUSE (a) Pulmonary stenosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE H. R. Guard			TITLE (SPECIFY) Assistant			DATE SIGNED 11/30/82		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/4/1982		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD	
24. FUNERAL DIRECTOR NAME Herbert E. Nuttall			ADDRESS 35 W. NORTH AVE.			25a. DATE REC'D. BY REGISTRAR DEC 1 - 1982		
						25b. REGISTRAR'S SIGNATURE John J. Connel		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

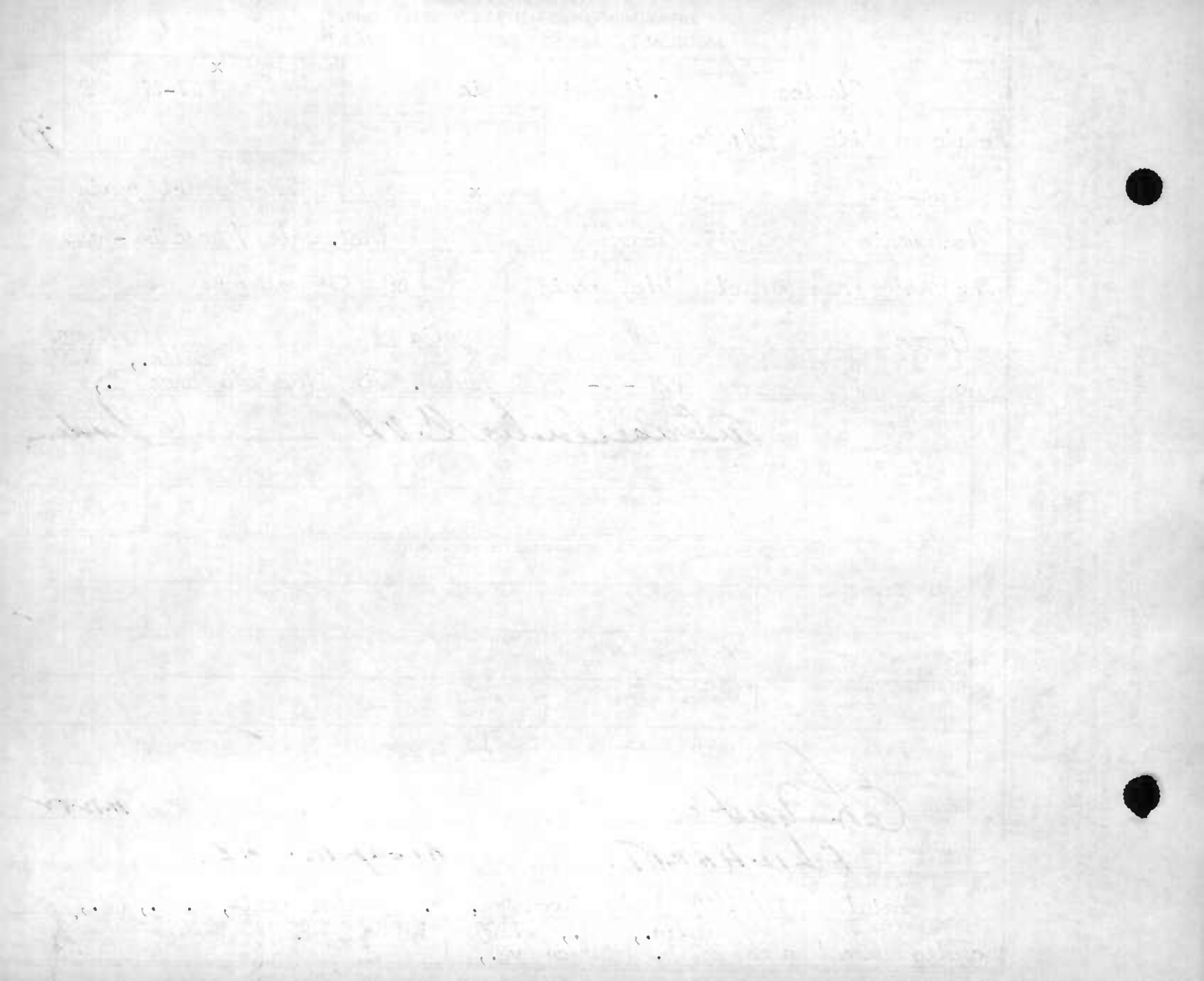
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

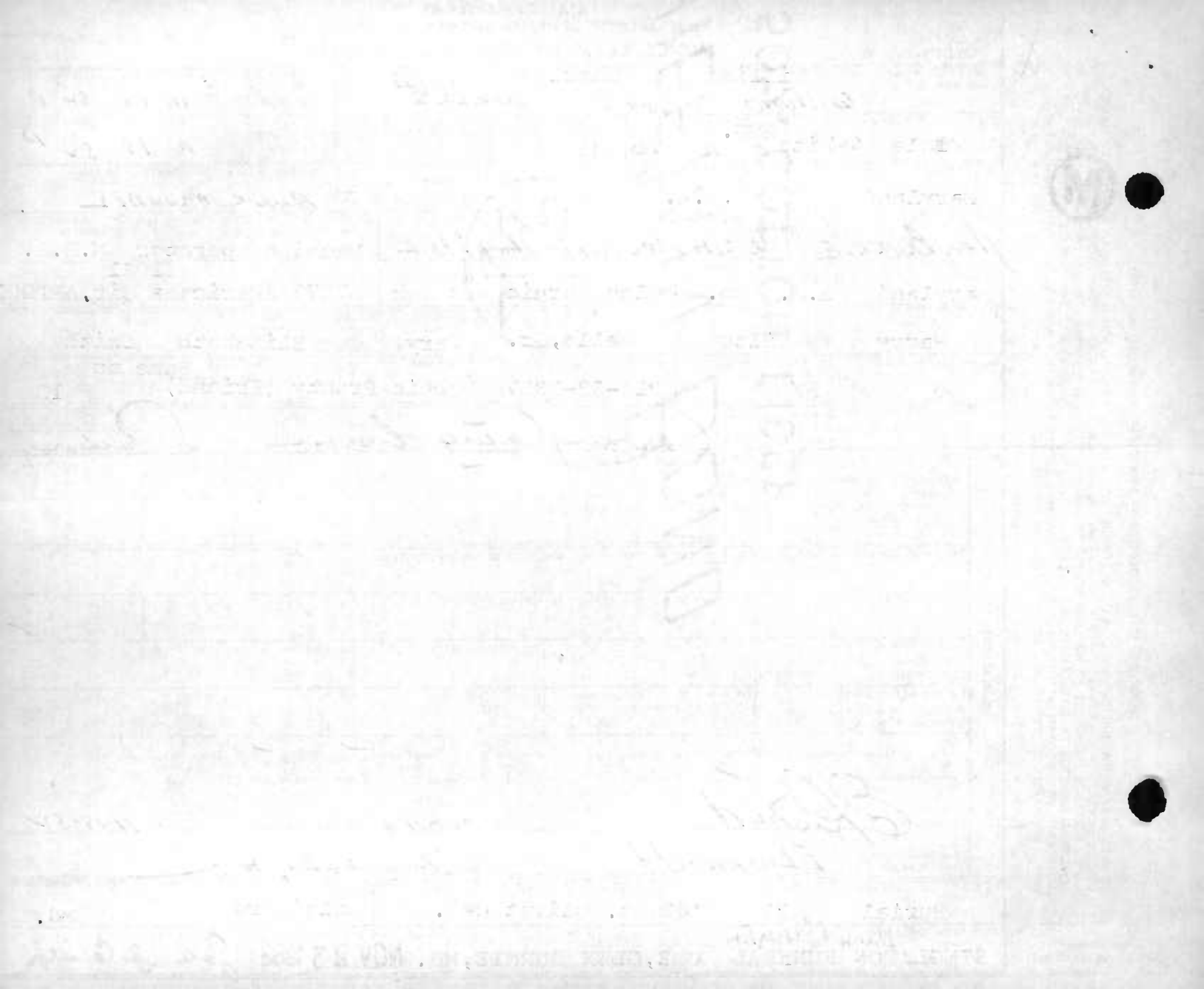
DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST William MIDDLE Charles LAST WELLS <i>William Charles Wells</i>		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>11 18 1982</i>		2b. HOUR <i>P</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH DAY MONTH YEAR <i>Aug 20 40</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>42 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR <i>11 18 1982</i>		2d. HOUR <i>P</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL</i> MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Arundel Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machine Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>M.B.A.</i>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Milton Wells, Jr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Smith</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-38-3337</i>		17. INFORMANT ADDRESS <i>Same as</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) <i>Deputy</i>		M.D. <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>11-18-82</i>	
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (TYPE OR PRINT) <i>ELINHARDT</i>		ADDRESS <i>Pennsylv, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>22 NOV'82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR NAME <i>William F. Charlton</i>		ADDRESS <i>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 23 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 7 B.S. 4  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		A.	
FIRST MIDDLE LAST		NOVEMBER 16, 1982		5:35 M	
ELIZABETH S. WERNER					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	90	IF UNDER 24 HRS	
				MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Germany	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Homemaker		Own Home
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MD.	A.A.	Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		105 New Jersey Ave. 21061	
Joseph Schroeder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-01-6662		Frank Werner 110 Greenway N.E. 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Pneumonia</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Senile Dementia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		P.M. 19		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11-11</i> , 19 <i>82</i> , to <i>11-16</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>11-16</i> , 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did; (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Paul S. Rhodes</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
PAUL S. RHODES, M.D.		1667 CROFTON CENTER CROFTON, MARYLAND 21114			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		18 Nov. 82		Holy Cross Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. COUNTY	
NAME ADDRESS		CITY OR TOWN		STATE	
James S. Kirkley F.H. Glen Burnie MD.		Brooklyn A.A.		MD.	
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NOV 17 1982		<i>John J. Smith</i>			

BP \_\_\_\_\_



PHOTOGRAPH

COLL

*Handwritten signature or name*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 7 8 8 5						
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD A. WHITE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 16, 1982</b>					2b. HOUR <b>5:00 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 6, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Edgewater</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PLEASANT LIVING CONVALES.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter - Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7 Riverview Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman R. White</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rhoda E. Stinchcomb</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-05-0945</b>		17. INFORMANT <b>James B. White</b> <b>165 Woodside Trail</b> <b>Annapolis, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR HEMORRHAGE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 HRS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC BRONCHOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)										18 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>9-4-72</b> , 19 <b>82</b> , to <b>11-16</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>11-16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Mr Goodman</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-16-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MW GOODMAN</b>					22e. ADDRESS <b>104 FORBES ST ANNAPOLIS MD 21404</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-18-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis, Anne Arundel, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b> ADDRESS <b>1212 West St., Anna., Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lauer</b>				

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243-29-25

1. 2000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. RETAIN PAGE 5. IF THE DEATH OCCURRED IN A HOSPITAL, GIVE THIS CERTIFICATE TO THE HOSPITAL. IF THE DEATH OCCURRED IN A HOME, GIVE THIS CERTIFICATE TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George White			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 11 11 1982			2b. HOUR M 8:15 a.m.		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 17 1918	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 11 1982		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Galesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 956 Benning Road - rear yard				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN GALESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 956 Benning Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST CHESTER WHITE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA HARRIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES-NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS NORMAN WHITE 1000 Rogers Rd. Churchton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9651 Shotgun wound of Thorax & Abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11 11 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot by police				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home - yard		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 956 Benning Road, Galesville, Anne Arundel Co., Md.				
22a. I certify that I took charge of the remains described above; held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 11-12-82	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-16-1982		23c. NAME OF CEMETERY OR CREMATORY EBENEZER CHURCH CEME.			23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR NOV 16 1982				
25b. REGISTRAR'S SIGNATURE 								



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 8 1

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>NOEL HARAN WHITE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-82</b>	
3. SEX <b>M</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 4 37</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) <b>250 Old Mill Bottom Rd.</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSURANCE SALESMAN</b>	
13a. STATE <b>MD.</b> 13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>250 Old Mill Bottom Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William HARAN WHITE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice ROUSSEAU</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>1 -</b>	
17. INFORMANT <b>CATHERINE WAHN WHITE</b>		ADDRESS <b>#13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1579</b> IMMEDIATE CAUSE (a) <b>La Parcar</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29/82</b> , 19____, to <b>10/31/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/29/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) the body after death.			
22b. SIGNATURE <b>S.W. Watkins</b>		22c. DATE SIGNED <b>11/1/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.W. Watkins</b>		22e. ADDRESS <b>121 CATHEDRAL ST. ANNAPOLIS MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/5/82</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS AA MD.</b>	
24. FUNERAL DIRECTOR NAME <b>TAYLOR F. CHAPEL</b> ADDRESS <b>ANNAPOLIS MD.</b>		25a. DATE RECD. BY REGISTRAR <b>NOV 3 1982</b>	
		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP 422

Item 19a&b Film 574 cn				STATE OF MARYLAND			
1- FOR STATE 12-20-82 cn REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF DEATH				8 2 2 7 8 8 8			
				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul J Wiegard				2a. DATE OF DEATH MONTH DAY YEAR 11 16 82			
3. SEX male				2b. HOUR 9 <sup>00</sup> PM			
4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 8-1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEAR) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BERNARD WIEGARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA ROEBECK		13e. STREET ADDRESS 605 Ridgley Ave.		21401	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-1446		17. INFORMANT RUTH CALLAHAN WIEGARD #13		ADDRESS 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Post-pneumonia sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 days 13 years			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 1973		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/16/82 to 11/16/82, that (I) (we) lost saw the deceased alive on 11/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard I. Hochman M.D., P.A.		22e. ADDRESS 16 MURRAY AVE ANNAPOLIS MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIED		23b. DATE 11-19-82		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEM.		23d. LOCATION (CITY OR TOWN) COUNTY STATE ANNAPOLIS A.A. MD.	
24. FUNERAL DIRECTOR NAME John M. Taylor Sons		ADDRESS ANNAPOLIS MD.		25a. DATE REC'D. BY REGISTRAR NOV 22 1982			
				REGISTRAR'S SIGNATURE John J. Connel			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 8 9

FOR  
STATE  
REGISTRAR

REG. NO.

E.S.T.

1. DECEASED NAME (TYPE OR PRINT) PAULINE MARGARET WILBUR			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27, 1982		2b. HOUR 11:05PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 30 1926		6. AGE (IN YEARS LAST BIRTHDAY) 56	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. — — — —
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY A.A. Co.	13c. CITY OR TOWN Müllersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Bessie Braun		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-22-5478	17. INFORMANT ADDRESS Same as # 13 Mr. Harry O. Wilbur, Sr. (HUSBAND)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Probable Pulmonary Embolism. DUETO, OR AS A CONSEQUENCE OF (b) Undifferentiated large cell carcinoma of left lung DUETO, OR AS A CONSEQUENCE OF (c) 2 months					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —	
22a. I certify that (I) (this hospital) attended the deceased from 11-16 1982, to 11-27 1982, that (I) (we) last saw the deceased alive on 11-27-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Pathmanathan		DEGREE M.D.		22c. DATE SIGNED 11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. PATHMANATHAN, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1 DEC '82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk., Elkridge Howard Md.	
24. FUNERAL DIRECTOR SINGLETON FUNERAL HOME		ADDRESS GLEN BURNIE, MD		25a. DATE REC'D. BY REGISTRAR NOV 30 1982	
				25b. REGISTRAR'S SIGNATURE John J. Casper	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11:02

11:02

NOVEMBER 27, 1985

WILLIAM

MARGARET

WILLIAM

ANN ARUNDEL COUNTY

NORTH ANN ARUNDEL HOSPITAL

ELLEN DUNN



11:02

11:02

11:02

11:02

325 HOSPITAL DRIVE, SUITE 104

ELLEN DUNN, M.D.

2. PATIENTS, M.D.

NOV 30 1985

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 9 0

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ida M. Wiley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 3 82</i>		2b. HOUR <i>1<sup>15</sup> A.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 11, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Millersville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Knollwood Manor Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Glen Burnie</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Sheets</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>278-05-0200</i>		17. INFORMANT ADDRESS <i>Mrs. Genevieve Morris SAME as #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4409

IMMEDIATE CAUSE (a)

*Cardiac Arrest*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*1 hour*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

*arteriosclerosis**years*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

*Diabetes mellitus*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21a. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>May 1982</i> to <i>Nov 3 1982</i> , that (1) <input checked="" type="radio"/> saw the deceased after death (2) <input type="radio"/> did not view the body after death.					
22b. SIGNATURE <i>David A. Schwartz</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/3/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID A. SCHWARTZ</i>		22e. ADDRESS <i>7845 Oakwood Road, Gb, Md 21061</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11/5/1982</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem Pk</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkridge, Howard, Maryland</i>
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 5 1982</i>	REGISTRAR'S SIGNATURE <i>John J. Conner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27891		
1. DECEASED NAME (TYPE OR PRINT) Samuel Hawes Willoughby III			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 1 19 82			2b. HOUR M						
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1950	6. AGE (IN YEARS) (LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 1 19 82		2d. HOUR 11:47				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County						
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Eng.		12b. KIND OF BUSINESS OR INDUSTRY Real Estate				
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 900 Eastham Court			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Hawes Willoughby Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn F. Riley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam 579 68 4733		17. INFORMANT ADDRESS Jeanne Willoughby			Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Drug Intoxication 9505 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11/1/19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self-ingested							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11 Eastham Ct. Crofton A.A. Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Hormez R. Guard</i>			TITLE (SPECIFY) M.D. Assistant					DATE SIGNED 11/1/82				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn St. Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4 Nov 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md				
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm						ADDRESS Funeral Home Inc Suitland, Md.			25a. DATE REC'D. BY REGISTRAR Nov 9 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

2



25

RECEIVED  
FEB 12 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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FEB 12 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 9 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert F. Wills SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 82</b>			2b. HOUR <b>5 A M</b>			
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 10 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Brooklyn Pk.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nurs. Ctr. Hammonds Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gang Leader</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>104 Maple Rd. (21090)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Wills</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth H. Hammond</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-18-8896</b>		17. INFORMANT ADDRESS <b>John Wills 604 Wood St. (21225)</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

**4292**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arteriosclerotic Cardiovascular disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L. Seenivasan, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SEENIVASAN, L.</b>				22e. ADDRESS <b>606 Hammonds Lane, Baltimore, Md. 21225</b>			

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce F.H. 4001 Ritchie Hgwy.</b>				25a. DATE RECEIVED BY REGISTRAR <b>NOV 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

BP

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George L. Brown, 1001 State Hwy.  
Baltimore, Md. 21225  
L. Greenbaum, N.Y.  
606 Kennedy Ave, Baltimore, Md. 21225

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 9 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillie E. Wilson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-82</b>		2b. HOUR <b>4 P</b> <sup>M</sup>
3. SEX <b>Female</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-2-16</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>EDGEWATER</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE COLLINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-28-8563</b>		17. INFORMANT ADDRESS <b>Edgewater, Md. 100 Mill Swamp Rd.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/26/82</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION <b>10/30/82</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracerebral Hemorrhage</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>20 Ridgely - Annapolis, MD - 21401</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29/82</b> to <b>11/5/82</b> , that (I) (we) lost saw the deceased alive on <b>10/29/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Jack Kuslner MD</b>		DEGREE <b>MD</b>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Kuslner</b>		22e. ADDRESS <b>20 Ridgely - Annapolis, MD - 21401</b>	

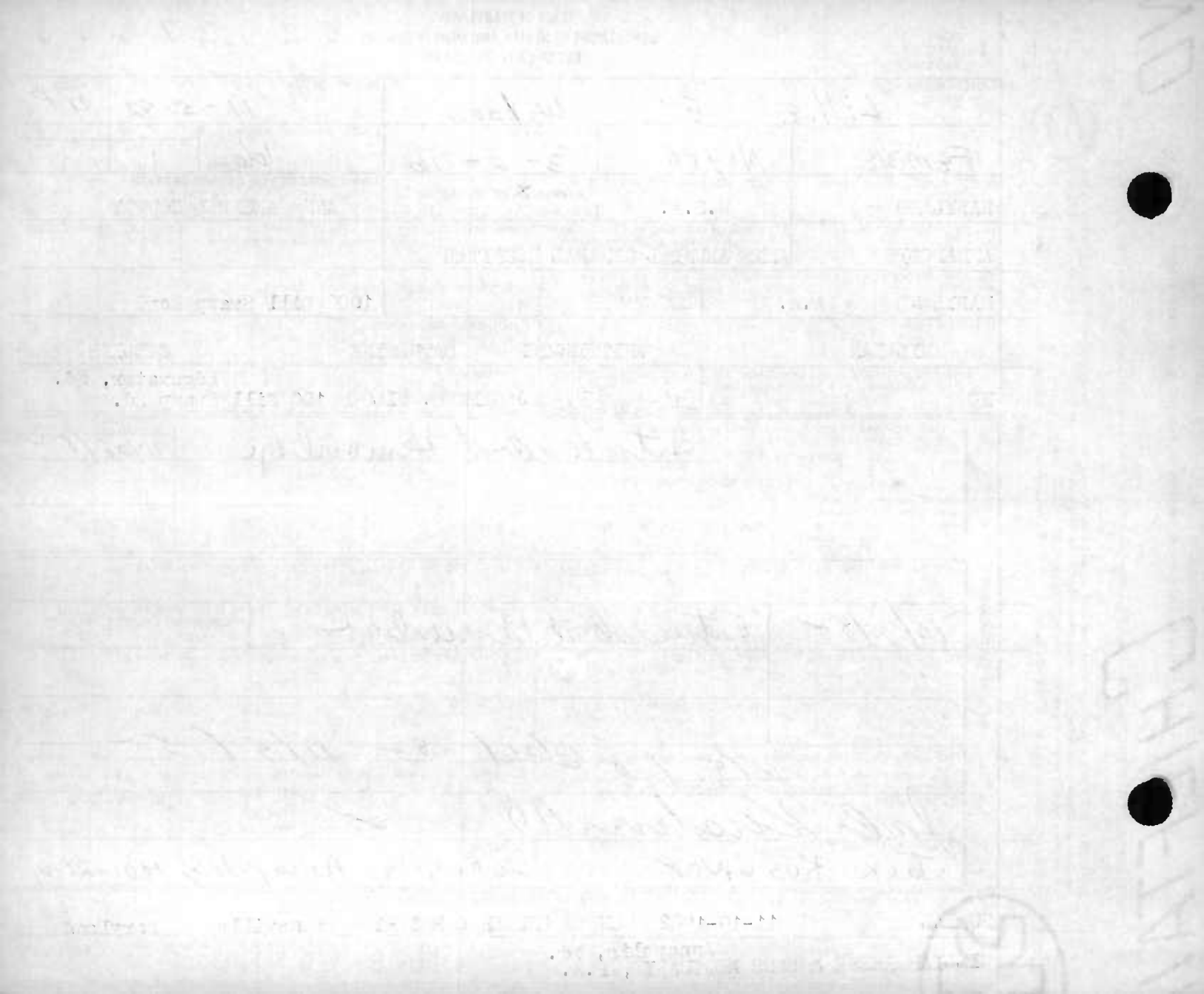
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11-10-1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHEWS CHURCH CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owensville Maryland</b>
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	2	7	8	9	4
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					FIRST M YRTLE C. LAST Wilson					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
SEX FEMALE					4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No					217-74-4606		Anne Leslie 3418 Hazelwood Rd. Edgewater Md. 21037									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4148 IMMEDIATE CAUSE (a) Ischemic Cardio myopathy																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Congestive Heart Failure						
										(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										22c. ADDRESS			22d. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)										22f. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial					11-17-82		Ft. Lincoln			Brentwood P.G. Md.						
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
T.A. HARDESTY ANNAPOLIS, MD. 21401										NOV 16 1982			John J. Conner			



Ischemic Cardiac Myopathy  
 Compensated Heart Failure



Revised N. K. Hoffmann



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 7 8 9 5

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>Antonia</i> MIDDLE: <i>M.</i> LAST: <i>Witowski</i>			2a. DATE OF DEATH MONTH: <i>11</i> DAY: <i>10</i> YEAR: <i>1982</i>		2b. HOUR M						
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH: <i>June</i> DAY: <i>13</i> YEAR: <i>1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.		IF UNDER 24 HRS HOURS: MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Pasadena</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>82 Circle Road,</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>82 Circle Rd., 21061</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Pasadena</i>							
14. FATHER'S NAME FIRST: <i>Stanley</i> MIDDLE: LAST: <i>Mazur</i>				15. MOTHER'S MAIDEN NAME FIRST: <i>Katherine</i> MIDDLE: LAST: <i>(unknown)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>217-01-2741</i>		17. INFORMANT ADDRESS <i>Helene W. Gudikunst Same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of gall bladder</i> <i>1560</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD &amp; CHF post MI</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Atherosclerosis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1981</i> , to <i>Sept</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Sept</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mustafa C OZ MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-11-82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mustafa C OZ MD</i>						22e. ADDRESS <i>605 B &amp; A Blvd Severna park Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11/13/1982</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, A. A. Co., Md.</i>		
24. FUNERAL DIRECTOR NAME <i>McGully Funeral Homes</i>						ADDRESS <i>Baltimore, Md., 21225</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 12 1982</i>		
						25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove copy from pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 9 6			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Norman W. Wittenman				2a. DATE OF DEATH MONTH DAY YEAR 11-7-82			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8-19-98		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE Arundel County MD	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diesel Engineer		12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Wittenman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS 139 Severn Way		21012	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-2145		17. INFORMANT Betty R. Wittenman		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>82</u> , to <u>11/7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE [Signature]		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACOB E. Teitelbaum		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (ECFY) Burial		23b. DATE Nov 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD	
24. FUNERAL DIRECTOR NAME John M. Taylor & Sons		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 21a & 21c Film 574 cn STATE OF MARYLAND										
1- STATE 12-7-82 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 7 8 9 7										
REGISTRAR CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carol Anne Ylinen					2a. DATE OF DEATH MONTH DAY YEAR November 2 1982					2b. HOUR 5:30p <sup>M</sup>
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 26 1969		6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Las Cruces, New Mexico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD				
10. CITY OR TOWN OF DEATH Ft. Meade		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Comm. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS -21144- 780 Stevenson Road		
14. FATHER'S NAME FIRST MIDDLE LAST Frank A Ylinen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah C. Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Father/ Frank A. Ylinen		ADDRESS same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Closed head injury 8280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Trauma - Internal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Cervical spine injury									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 1 1/2 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 2										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Approx.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 P.M. Nov 2 1982		21c. HOW INJURY OCCURRED Person was riding Horse Thrown into a tree by a horse						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Farm		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1763 Severn Chapel Road Anne Arundel						
22a. I certify that (I) (this hospital) attended the deceased from 2 Nov 19 82, to 2 Nov 19 82, that (I) (we) last saw the deceased alive on 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Accident										
22b. SIGNATURE Charles A. Peck Jr. MD					22c. DATE SIGNED Nov 2, 1982			22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. PECK, JR., MD, MC, M.D.		
22e. ADDRESS Kimbrough Army Community Hospital, Ft. Meade/										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 Nov. 82		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer				
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MARYLAND					25a. DATE REC'D. BY REGISTRAR NOV 5 1982					
25b. REGISTRAR'S SIGNATURE John S. Smith										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

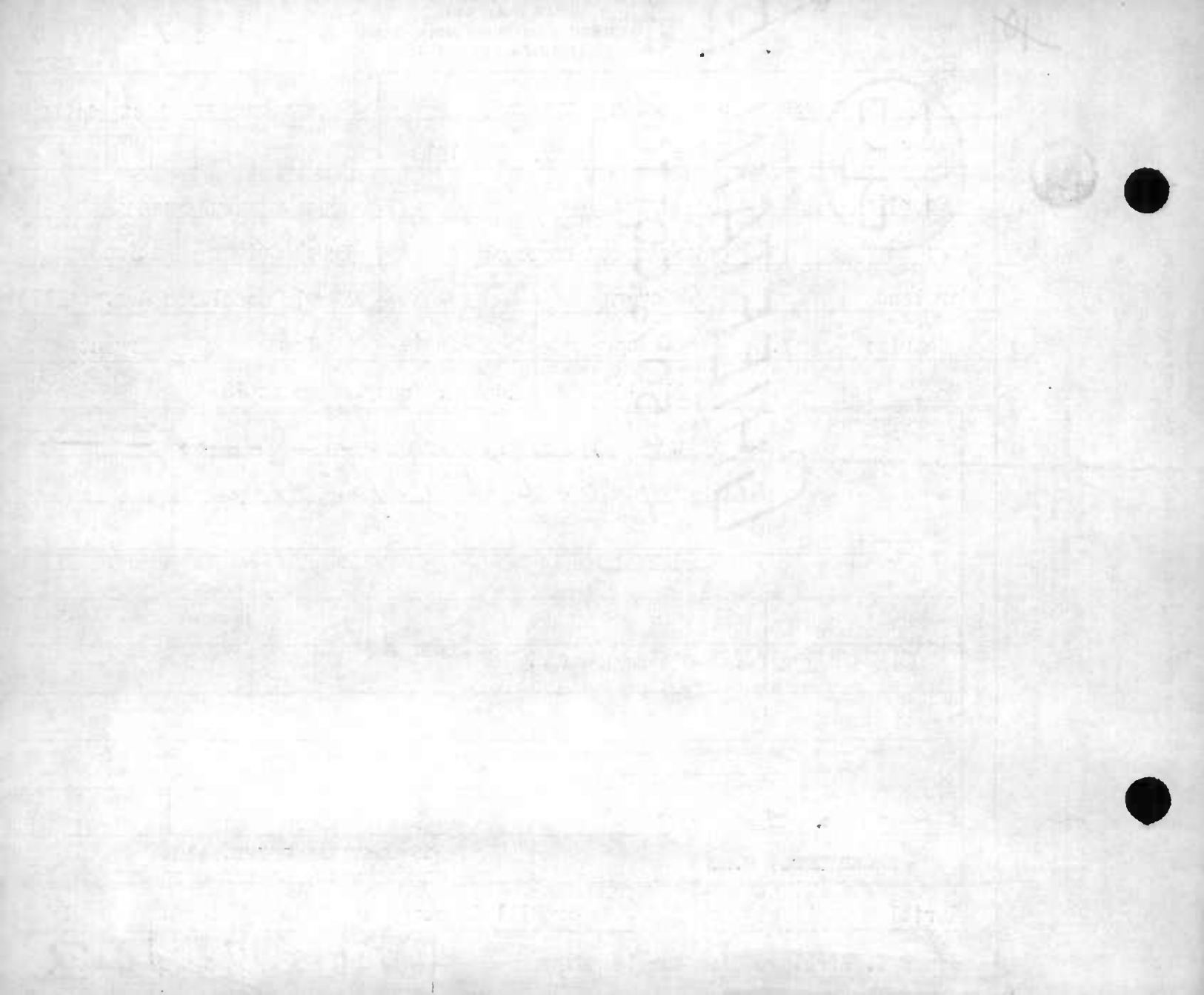
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1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE WASHINGTON YOUNG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 17, 1982</b>			2b. HOUR <b>1:00P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 13, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver - Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>755 Old Donaldson Ave. 21144</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Y. Young</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Tom Bryant</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-18-5888</b>		17. INFORMANT ADDRESS <b>Edna R. Young, Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4100 Acute massive Anterior wall</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>myocardial Infarction</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Recep Erol</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M.D.</b>				22e. ADDRESS <b>325 HOSPITAL DRIVE, #104 GLEN BURNIE, MARYLAND 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>20 Nov 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore AA MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>James S. Kirkley, Glen Burnie, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 7 8 9 9			
FOR Items 11 Phone 11-17-82				1 - STATE REGISTRAR			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
James A. Young				11-6-82 12:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
male		NEGRO		1-24-95		87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.		U.S.A.				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
DEALE		Anne Arundel Gen. Hosp.		RET.		FED. GOV'T	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		ANNE ARUNDEL		DEALE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
WILLIAM		SUSIE		YES		579-52-4507	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		20a. AUTOPSY?	
716 Whittington Dr.		BLAKE				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. PART 1: CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		22. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
4100 MYOCARDIAL INFARCTION				BURIAL		11-12-82	
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
4100		MYOCARDIAL INFARCTION		ARLINGTON NAT.		ARLINGTON, VA.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) ARTERIO SCLEROSIS		24. FUNERAL DIRECTOR NAME		25. DATE RECD. BY REGISTRAR	
		DUE TO, OR AS A CONSEQUENCE OF		ROBT. G. MASON		NOV 9 1982	
		(c)		ADDRESS		25b. REGISTRAR'S SIGNATURE	
				1661 GOOD HOPE RD. S.E.		John J. Conner	

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